

## Notice of Independent Review Decision

### **DATE OF REVIEW:**

04/14/2010

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Left total knee arthroscopy, computer assisted surgical navigation and inpatient stay three to five days.

### **A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified Orthopaedic Surgeon

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**The requested left total knee arthroplasty, computer assisted surgical navigation and inpatient stay of three to five days is not medically necessary.**

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 03/30/10 xxxxx Referral
- 03/30/10 Notice To Utilization Review Agent of Assignment, , DWC
- 03/30/10 Facsimile Transmittal with note from, xxxxx
- 03/30/10 Notice To xxxxx, LLC Of Case Assignment, , DWC
- 03/29/10 Confirmation Of Receipt Of A Request For A Review, DWC
- 03/26/10 Request For A Review By An Independent Review Organization
- 03/17/10 peer review report from , M.D.
- 03/08/10, 03/18/10 Preauthorization Determination letters, xxxxx
- 03/02/10, 03/12/10 Preauthorization Requests
- 11/06/08 to 08/14/09 Injection notes, , M.D., xxxxx
- 08/26/08 to 02/11/10 Office Visit notes, , M.D., xxxxx
- 08/08/08 MRI left knee, Hospital
- Note: Carrier did not supply ODG Guidelines.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured individual is a male who sustained a work-related injury on xx/xx/xx when he jumped off a wall at a construction site and developed medial left knee pain. He has been treated with Mobic,

Ultram, Tylenol #3, Glucosamine/Chondroitin, Synvisc injections, and a steroid injection. Physical exam is significant for normal motion and medial joint line tenderness. MRI reveals medial compartment chondromalacia and an extruded medial meniscus. Radiographs of the left knee are documented as showing medial and patella joint space narrowing.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The injured individual has chronic left knee pain and has undergone extensive conservative treatment. Radiographs reveal severe chondromalacia in the medial and patellofemoral compartments, but there is no report submitted for review. There is no mention of the injured individual's BMI in the notes. 2010 Official Disability Guidelines criteria for total knee arthroplasty are attached. The injured individual does not meet all of the criteria for surgery secondary to no documentation of BMI less than 35 and no evidence of osteoarthritis either on arthroscopy or standing radiographs. Therefore, based on the documentation, the medical necessity for the requested procedure is not substantiated.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines

Indications for Surgery -- Knee arthroplasty:

Criteria for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement is indicated. If 2 of the 3 compartments are affected, a total joint replacement is indicated.):

1. Conservative Care: Medications. AND (Visco supplementation injections OR Steroid injection). PLUS
2. Subjective Clinical Findings: Limited range of motion. AND Nighttime joint pain. AND No pain relief with conservative care. PLUS
3. Objective Clinical Findings: Over 50 years of age AND Body Mass Index of less than 35. PLUS
4. Imaging Clinical Findings: Osteoarthritis on: Standing x-ray. OR Arthroscopy.

[\(Washington, 2003\)](#) [\(Sheng, 2004\)](#) [\(Saleh, 2002\)](#) [\(Callahan, 1995\)](#)