

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 05/04/2010

IRO CASE #:

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

This case was reviewed by a Orthopedic Surgery Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right total knee replacement 27447 3 day LOS

REVIEW OUTCOME

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

Overtuned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 07-01-08 MRI right knee read by
- o 07-30-08 Orthopedic progress notes from
- o 08-14-08 Operative report - knee arthroscopy - from
- o 08-20-08 Orthopedic progress reports - 6 reports through 12/23/08 from
- o 11-19-08 Right knee MRI read by
- o 11-20-09 Medical Evaluation report from (DDE?)
- o 01-20-09 Orthopedic progress reports - 12 reports through 11/04/09 from
- o 01-26-10 Orthopedic progress notes from
- o 03-05-09 Operative report -right knee - from
- o 03-08-09 Letter of medical necessity from
- o 03-12-10 Request for preauthorization from
- o 03-09-10 Orthopedic progress notes from
- o 03-17-10 Medical rationale for xxxx from
- o 03-17-10 Adverse Determination Letter from
- o 03-22-10 Fax request for appeal from
- o 04-07-10 Adverse Determination Letter on Reconsideration from
- o 04-20-10 Request for IRO from the Claimant
- o 04-25-10 Confirmation of Receipt of Request for IRO from TDI
- o 04-26-10 Notice to PNS of Case Assignment of IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a -year-old male who sustained an industrial injury to the right knee on xx/xx/xxxx when the ground gave way and formats fell on him. He was hit on the back, forcing him to fall onto his knees. He is status post right knee arthroscopies with partial medial and lateral meniscectomies on August 14, 2008 and March 5, 2009.

MRI of July 1, 2008 showed complex tear body and posterior horn medial meniscus. Small peripheral tear lateral meniscus. High grade MCL sprain. Significant lateral patellar subluxation with chondromalacia. Moderate effusion without loose body and prepatellar bursitis.

Following arthroscopy in August 2008 the patient attended post-operative PT. On October 8, 2008 he was attending PT and still using a cane. On November 11, 2008 he was noted to have recurrent episodes of pain and difficulty with clicking and popping. The knee was aspirated on that date. In November 2008 locking, popping and episodes of giving way were reported. On December 23, 2008 a repeat arthroscopy was recommended.

MRI of November 19, 2008 showed trochlear dysplasia with lateral patellar tilt, early chondromalacia patella and large joint effusion/synovitis. There is a medial meniscus tear, lateral meniscus tear, medial collateral ligament tear, partial tear insufficiency of the ACL and lateral collateral ligament tear. There is an early chondromalacia at the medial and lateral knee joint compartments.

Following the second arthroscopy of March 5, 2009 significant post surgical effusion developed and the knee was aspirated on March 18, 2009. The patient attended post-operative PT and rehabilitation. On May 6, 2009 he was still walking with antalgic gait and using a cane. He attended a work conditioning program, but on June 17, 2009 he is noted to be having difficulty due aggravation of his pain with therapy. There is mention that he will most likely require a TKR in the future. X-rays showed complete loss of cartilage space.

On July 15, 2009 recommendation was made for the patient to undergo a TKR. He is age and will clearly need additional surgery in the future, but "at this time there is no other way to treat his painful condition without TKR." Surgery was denied and cortisone injection was provided and Synvisc recommended. A benefit review conference was requested on September 15, 2009 to settle the issue. On September 23, 2009 the patient was provided a Synvisc-One injection. On November 4, 2009 the patient reported the Synvisc was helpful for only two days.

On March 19, 2009 a custom knee brace was requested for the patient.

The patient underwent a Require Medical Examination on October 20, 2009 which was submitted to the Disability Determination Officer. The patient continues to work as a carpenter. He has a history of depression, weight gain and sexual problems. He has had two surgeries to the right knee. He is using Celebrex and ibuprofen. Right knee MRI of July 1, 2008 showed, complex tear body and posterior horn medial meniscus. Small peripheral tear lateral meniscus. High grade MCL sprain. Significant lateral subluxation with chondromalacia. Moderate effusion without loose body. Prepatellar bursitis. He underwent arthroscopy on August 14, 2008 with partial medial and lateral meniscectomy. He has degenerative lumbar disc disease. He underwent a second arthroscopy on March 5, 2009 with partial medial and lateral meniscectomy. On June 16, 2009 his orthopedic provider noted recurrent effusion and limited mobility. Standing x-rays with 45 degrees flexion found loss of medial cartilage space. Work conditioning was aggravating his problem and the provider recommended total knee replacement (TKR). Review of records noted an examination dated September 28, 2009 which stated, his weight was listed as 329 pounds, 60 pounds more than reported today (which would be 269 pounds). This report also noted the patient was using a cane, had effusion and crepitus and concluded, his problems appeared to be related to osteoarthritis and he might need a TKR. Per the RM examiner, the patient complains of pain all day made worse with walking. He reports a pain level of 10/10. He reports numbness in the right foot. He is limited by weakness. He is "5' 5" and 260 pounds" (BMI = 43.3). He is unable to squat. He is unable to stand on one leg. He is tender to palpation. Straight leg raise is negative. He is neurologically intact. Effusion is noted. There is medial and lateral joint line tenderness. Ligaments are intact. McMurray's is positive. Right knee flexion is 57/150 and extension is -12/0. Right quad strength is 4/5. Diagnosis is osteoarthritis right knee, lumbar sprain and torn lateral and medial meniscus right knee. He has developed posttraumatic osteoarthritis of the right knee. In order to return to gainful employment he needs a TKR as soon as possible. While he is technically too young for an artificial knee by standard clinical guidelines, a TKR is the only solution to his particular problem at this time and he represent and outlier to those guidelines. An FCE is ordered. Work restrictions are assigned.

On January 26, 2010 the patient was waiting for approval for total knee replacement for his traumatic cartilage damage. He has persistent chronic pain and difficulty with range of motion. On March 9, 2010 his provider noted the patient had attended an RME and recommendation was to proceed with a TKR despite his young age.

Request for right TKR was considered in review on March 17, 2010 with recommendation for non-certification. Per the reviewer, the patient has attended PT (number of visits unknown) without significant benefit and work conditioning was aggravating his problem more than helping it. He is using a custom knee brace, length of use and response not reported. A peer discussion was attempted but not realized. MRI of November 19, 2008 showed trochlear dysplasia with lateral patellar tilt, early chondromalacia patella and large joint effusion/synovitis. There is a medial meniscus tear, lateral meniscus tear, medial collateral ligament tear, partial tear insufficiency of the ACL and lateral collateral ligament tear. There is an early chondromalacia at the medial and lateral knee joint compartments. The submitted reports do not include PT progress notes or records of pain medications used. The physical examination of the knee regarding gait analysis was not presented for review. There was no official documentation of radiographs of the right knee in a standing position. The patient's BMI was not reported.

On March 17, 2010 the provider submitted medical rationale for TKR with request for reconsideration. Per the provider, there was not a request for specific information. How can the provider be held responsible for providing records with regard to PT after

surgery, gait analysis, and other aspects of the patient's care when they are already documented in a chart that is already quite thick from his date of injury. With regard to treatment, he has been treated conservatively for an extended period of time since his surgery. Treatment has included PT, cortisone shots, anti-inflammatory medication and he was even approved for one Synvisc-One injection that was performed in August 2009. "I did fail to include his BMI but noted in the progress report he is 5' 8 and 296 pounds, which makes a BMI of 45. His standing x-rays of August 18, 2009 show near complete loss of cartilage space, which means there is less than 1 mm left of cartilage space within the medial compartment of his knee. With regard to gait analysis, he walks with a limp and uses a cane constantly throughout the day. Any other needed information can be found in the charts which have been provided to the carrier.

Request for reconsideration right TKR was considered in review on April 7, 2010 with recommendation for non-certification. The patient is using Motrin, dosage not reported. Injection of 9/23/09 helped him for 2 days. Response to injection of 3/18/09 and 8/18/09 is not reported. Lumbar MRI performed 11/19/08 was summarized. The radiology report, not submitted, shows spondylosis, disc disease, and posterior element hypertrophy. Right knee x-rays 6/17/09, radiologist report not provided, showed loss of the medial cartilage space. PT, unknown number of sessions, has not helped him. Uses a brace, frequency and duration not reported, response not reported. Diagnosis is localized osteoarthritis. He is using Motrin (dosage and frequency not stated). He had one Synvisc injection on 9/30/09, which helped him for 2 days. Cortisone injections on 3/18/09 and 8/18/09 were not helping. A peer discussion was attempted but not realized. Recent clinical notes of 1/26/09 showed slight pain at extreme motion with limited mobility with continued difficulty with ROM. It was noted that the patient did have PT, but no recent PT reports were submitted to document progress with PT. A detailed description of the gait analysis of the patient is needed to assess the cause of the limp. The standing radiograph was noted in the clinical notes of 8/18/09, which was more than 6 months old with no official result. The documented BMI of the patient on 7/15/09 was 45, which exceeds the recommended BMI set forth by ODG.

The patient requested an IRO.

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

ODG 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.

The patient has osteoarthritis per standing x-rays. He has attempted medications, injections and Viscosupplementation. He has constant intractable pain of a significant level. He has effusion and crepitus and loss of motion and uses a cane. On September 28, 2009 the patient's weight was listed as 329 pounds. On October 20, 2009 the patient's weight was stated to be 260 pounds. His height is variously reported as 5'5" and 5'8". Report of September 28, 2009 also noted the patient was using a cane, had effusion and crepitus at the knee and concluded, his problems appear to be related to osteoarthritis and he might need a TKR. Per the RM examiner, the patient complains of pain all day made worse with walking. He reports a pain level of 10/10. He reports numbness in the right foot. He is limited by weakness. RME opinion is for TKR.

The patient meets all criteria for TKR with exception of being over 50 years of age and having a Body Mass Index of more than 35. ODG does state that, after total knee arthroplasty (TKA) for osteoarthritis of the knee, obese patients fare nearly as well as their normal-weight peers. A British research team reports that higher BMI (up to 35) should not be a contraindication to TKA, provided that the patient is sufficiently fit to undergo the short-term rigors of surgery. I would agree with the RME opinion that this patient represents an outlier to the guidelines (He has developed posttraumatic osteoarthritis of the right knee. In order to return to gainful employment he needs a TKR as soon as possible. While he is technically too young for an artificial knee by standard clinical guidelines, a TKR is the only solution to his particular problem at this time and he represents and outlier to those guidelines.)

Therefore, recommendation is to disagree with the previous non-certification for right total knee replacement 27447 3 day LOS

The IRO's decision is consistent with the following guidelines:

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

____ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL &

ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

The Official Disability Guidelines (04-27-2010) Knee and Leg Chapter:

Recommended as indicated below. Total hip and total knee arthroplasties are well accepted as reliable and suitable surgical procedures to return patients to function. The most common diagnosis is osteoarthritis. Overall, total knee arthroplasties were found to be quite effective in terms of improvement in health-related quality-of-life dimensions, with the occasional exception of the social dimension. Age was not found to be an obstacle to effective surgery, and men seemed to benefit more from the intervention than did women. Total knee arthroplasty was found to be associated with substantial functional improvement.

After total knee arthroplasty (TKA) for osteoarthritis of the knee, obese patients fare nearly as well as their normal-weight peers. A British research team reports that higher BMI (up to 35) should not be a contraindication to TKA, provided that the patient is sufficiently fit to undergo the short-term rigors of surgery.

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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.