



Notice of Independent Review Decision

DATE OF REVIEW: 11/16/10

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for total knee replacement (CPT 27447) and Inpatient Surgical Room (RC111).

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

Texas licensed orthopedic surgeon

REVIEW OUTCOME:

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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 previously denied request for total knee replacement (CPT 27447) and Inpatient Surgical Room (RC111).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Pre-Authorization Request dated 11/9/10, 10/5/10.
- Subsequent Medical Report Worker's Compensation dated 11/3/10, 8/25/10, 7/28/10, 7/21/10, 6/25/10, 6/7/10, 4/14/10, 3/17/10, 3/10/10, 2/17/10.
- Adverse Determination Letter dated 10/21/10, 9/24/10.
- Problem Focused History dated 10/12/10, 8/16/10, 1/12/10.
- Range of Motion/Muscle Test dated 10/12/10, 8/16/10.
- Physical Performance Evaluation dated 7/20/10.
- Operative Report dated 3/11/10.
- Specimen Results dated 3/11/10.
- Chest X-Ray Report dated 3/4/10.
- Lab Results dated 3/4/10.
- Right Knee MRI Report dated 2/2/10.
- There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Patient fell and landed on his right knee.

Diagnosis: Degenerative right knee

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

This xx male was injured on xx/xx/xx. The mechanism of injury occurred when he fell onto his right knee. The most recent diagnosis was a degenerative right knee and a right total knee replacement has been requested. A 02/02/10 MRI of the right knee showed a joint effusion, synovitis, and a tear of the entire medial meniscus with amputation and a bucket handle fragment centrally displaced. There was narrowing of the medial compartment with subchondral edema. A tear of the lateral meniscus was seen with minimal subchondral edema of the posterior lateral femoral condyle. The anterior cruciate ligament and posterior cruciate had partial tearing. There was minimal patellar tendinosis and subchondral edema of the tibial eminence and trochlear notch probably due to chronic synovitis. Dr. saw the claimant in follow up and recommended surgery after he had reviewed the MRI. The claimant was taken to the operating room on 03/11/10 for a right knee arthroscopy with partial medial and lateral meniscectomy, chondroplasty and micro-drilling of the medial tibial plateau and femoral condyle for large osteochondral defect of the weight-bearing surfaces, synovectomy, and chondroplasty of patella for areas of chondromalacia. On 03/17/10, Dr. noted the claimant was doing well. He was referred for therapy and given Celebrex. By 04/14/10, the claimant still had right knee pain. There was mild quadriceps atrophy, motion 0-110 degrees, and medial joint line pain. Viscosupplementation and Naproxen were recommended. The 06/07/10 note

from Dr. reported the injections had been denied based on a pre-existing condition. Dr. noted that the injury to the right knee produced the complex tear that caused significant chondromalacia due to the mechanical symptoms and inflammation. Viscosupplementation was again requested and approved. A 08/16/10 visit with Dr. noted the claimant had 0-90 degrees motion. There was tenderness to the right hamstring and quadriceps. Strength was 4/5. The claimant had a positive Apley's and patellar grind. Dr. recommended that the claimant continue work hardening and his pain medication. On 08/25/10, Dr. reported that the claimant had no improvement with the injections. Motion was 0-110 degrees; there was quadriceps atrophy and medial joint line pain. A right total knee arthroplasty was recommended. The surgery was denied two times and now an IRO has been requested. On overview of this case, the claimant is of an acceptable age for arthroplasty. The medical records would confirm the presence of degenerative change both by MRI and arthroscopy. Conservative care has included medications including multiple anti-inflammatories and viscosupplementation. These appear to have failed. Limitation of motion has been documented. Absence of relief with conservative treatment has been documented. In all likelihood, this claimant will satisfy Official Disability Guidelines criteria for total knee arthroplasty. However, the treating physician must make height and weight or a calculated body mass index available for review. There also needs to be documented evidence of the presence of nighttime pain and the presence of significant degenerative change on standing radiographs. If these three simple clarifications can be provided, then, in all likelihood, the surgery can be deemed medically necessary. However, absent those pieces of information, medical necessity for a total knee replacement (CPT 27447) cannot be established under the guidelines. Since surgery is not medically necessary, there is no necessity for the inpatient surgical room (RC111). Therefore, the previous adverse determinations are upheld.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
Knee chapter, Knee joint replacement
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).