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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/22/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Total Knee Replacement

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

M.D. Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI right knee 09/04/10

Dr. office visits 03/18/11, 04/01/11, 04/11/11, 04/29/11, 05/13/11, 05/27/11, 06/13/11, 07/12/11

Peer review reports 06/20/11, 06/29/11

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates, Knee and Leg, Knee Joint Replacement

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a work-related injury being evaluated for a request for right total knee replacement. The claimant's record contains a right knee MRI indicating moderate medial compartment degenerative joint disease as well as maceration of the posterior horn of the medial meniscus. This claimant has a series of orthopedic office evaluations from 03/18/11 through 07/12/11. On 03/18/11, the claimant is reported to have had arthroscopy of the right knee with medial meniscectomy and debridement on 12/16/10. The claimant is now reporting sharp right knee pain and limited function. The examination is positive for varus deformity and 2+ effusion, positive for patella grinding, positive for tenderness at the medial joint line, positive McMurray's test. The right knee range of motion is minus 5 to further flexion of 100. The claimant's assessment is work-related right knee medial meniscal tear with pre-existing medial compartment degenerative disease with a varus deformity. The claimant underwent a corticosteroid injection.

On 04/11/11, the claimant reports improvement following the recent steroid injection. The examination showed a small joint effusion, varus deformity and tenderness at the medial joint line with range of motion at minus 5 to 110 degrees of flexion. The recommended treatment is to apply a medial unloader brace to protect the medial compartment from future deterioration.

Followup on 05/13/11 indicates the claimant underwent knee joint aspiration and is using a support orthosis along with therapy and reports recently increased pain and swelling. The claimant's physical examination is similar to prior examinations with varus deformity, 2+ joint effusion, medial joint line tenderness, plus range of motion 5 to 100. The claimant underwent a second corticosteroid injection.

On 06/13/11, the claimant reports continued right knee pain and swelling with similar findings on physical examination, as indicated in the record, compared to previous examinations. The claimant is assessed that he will benefit from a right total knee replacement.

On 07/12/11, the claimant continues to report right knee pain and swelling. The record indicates the knee replacement surgery was denied by insurance. The claimant's physical examination is unchanged based on the examination, as noted in the report. It is again assessed that the claimant will benefit from a right total knee replacement.

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

Official Disability Guidelines knee and leg chapter on knee joint replacement outline criteria for total knee replacement. Conservative care should include medications along with viscosupplementation or steroid injection. Criteria recommend a body mass index of less than 35 in order to proceed with total knee replacement along with imaging clinical findings suggesting osteoarthritis on a standing x-rays or arthroscopy. In the claimant's case, it is noted that he had a steroid injection times two, but no viscosupplementation. The claimant did take medications such as nonsteroidal anti-inflammatory. The claimant is years of age, but his body mass index cannot be calculated. Additionally, the grading of the osteoarthritis cannot be determined. There is no report of a standing weightbearing x-ray indicating severe joint space loss. The MRI indicates only moderate osteoarthritis. Absent documentation of the claimant's body mass index, absent a trial of viscosupplementation in addition to corticosteroids, and given the fact that on review of the available records the claimant osteoarthritis does not appear to be advanced enough to warrant a total knee replacement, the request for right total knee replacement is not found to be medically necessary at this time.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates, Knee and Leg, Knee Joint Replacement

ODG Indications for Surgery| -- Knee arthroplasty

Criteria for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement may be considered. 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, where increased BMI poses elevated risks for post-op complications. PLUS
4. Imaging Clinical Findings: Osteoarthritis on: Standing x-ray. OR Arthroscopy

(Washington, 2003) (Sheng, 2004) (Saleh, 2002) (Callahan, 1995)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS). See also Skilled nursing facility LOS (SNF)

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

ACOEM-AMERICA 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)