

# Wren Systems

An Independent Review Organization  
3112 Windsor Road #A Suite 376  
Austin, TX 78703  
Phone: (512) 553-0533  
Fax: (207) 470-1064  
Email: manager@wrensystems.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Aug/18/2011

**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**

Official Disability Guidelines  
Clinical records Dr., 6/16/93, 4/25/95  
Clinical records Dr., 3/1/11, 6/28/11, 11/30/10, 2/16/10, 9/7/10, 5/4/10, 11/17/09, 8/20/09, 5/21/09, 9/15/05, 2/21/02, 11/14/02  
Utilization review determination dated 07/08/11  
Utilization review determination dated 07/29/11  
Exam Notes, 1992, 1993  
Procedure Report, 11/15/93,  
Cardiolite SPECT scan dated 03/14/11  
EKG dated 03/14/11  
Clinical records Dr., 3/3/11  
Independent medical examination Dr. dated 08/17/99  
Functional capacity assessment dated 08/10/99  
Patient Letter, 7/27/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who is reported to have sustained work related injuries to his right knee on xx/xx/xx. On the date of injury he twisted his knee while loading a truck. He was diagnosed with degenerative joint disease and osteoarthritis of the right knee. The submitted clinical records indicate the claimant was treated for osteoarthritis of the right knee with oral medications, physical therapy and exercise. He ultimately underwent arthroscopic debridement onxx/xx/xx. Records indicate the claimant has progressively marked degenerative changes of bilateral knees right greater than left. The claimant was documented as subsequently receiving corticosteroid injections and later viscosupplementation. The most recent clinical records indicate the claimant did not receive benefit. Radiographs indicate end stage tricompartmental osteoarthritis. Conservative

treatment measures have included nonsteroidal anti-inflammatory drugs, corticosteroid injections and viscosupplementation. He subsequently requires narcotics to control pain. The most recent clinic note dated 06/28/11 indicates the claimant has continued discomfort in the knee. He has an antalgic gait. He has increasing left knee pain. Radiographs continue to show bone on bone findings with tricompartmental disease. A request was made by the patient's provider for right total knee replacement.

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

The reviewer finds that this request for right total knee replacement is medically necessary. The submitted clinical records indicate that the claimant has exhausted all conservative treatment. He is noted to have end stage osteoarthritis and meets criteria per Official Disability Guidelines for performance of total knee arthroplasty. It is noted that the medical records for the claimant's cardiac workup indicate that the claimant is six feet tall and weighs 241 pounds with a resultant BMI of 32.69. This is below 35 and as a result the claimant meets all criteria for the performance of a right total knee arthroplasty. Based upon the submitted clinical information, and upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

**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)