Notice of Independent Review Decision

DATE OF REVIEW: 12/22/10
DATE OF AMENDMENT: 01/04/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Total Knee Arthroplasty

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

Board Certified in Orthopedic Surgery

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.

Total Knee Arthroplasty - OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office Visit, M.D., 06/24/10, 07/26/10, 08/10/10, 08/17/10, 08/30/10, 09/08/10, 09/20/10, 09/28/10, 10/04/10, 11/05/10
- Follow Up Office Note, D.O., 06/24/10, 07/09/10, 08/09/10, 09/08/10, 10/08/10
- New Patient Evaluation, Dr. 06/28/10
- Physician's Prescription and Statement of Medical Necessity, Dr. 06/28/10
- Pre-Authorization Request, Dr. 06/29/10
- Left Knee MRI, Dr. 07/01/10
- Treatment Orders/Plan of Care, Rehabilitation Center, 07/26/10
- Initial Evaluation, RehabMed, 07/27/10
- Pre-Certification/Concurrent Revier, Dr. 07/27/10
- Physical Therapy, RehabMed, 07/27/10, 08/03/10, 08/05/10, 08/06/10, 08/10/10, 08/12/10, 08/13/10, 08/17/10, 08/19/10, 08/20/10
- Approval Letter, 07/29/10, 09/14/10
- DWC Form 73, Dr. 08/10/10, 08/30/10, 10/04/10
- Left Knee X-rays, Dr. 08/17/10, 09/08/10, 11/05/10
- Therapy Orders, Dr. 09/08/10
- Denial Letters, 11/12/10, 11/24/10

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient complained of left knee pain. An MRI of the left knee noted small joint effusion with apparent tear in the body and posterior horn of the medial meniscus. The claimant was treated conservatively with physical therapy and medication. Medications included Motrin and Hydrocodone. Euflexxa injections were also performed to the left knee.

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

Yes, the total knee arthroplasty is medically reasonable and necessary. The ODG criteria for total knee arthroplasty include:

1. The patient has subjective complaints of knee pain and night pain, unrelieved.
2. Also, conservative treatment, medications, and viscosupplementation or steroid injection.
3. The patient is objectively over 50 and has a body mass index of less than 35 (the patient is noted to be 65 inches and 175 pounds, which is under the 35 BMI).
4. The patient has osteoarthritis on standing x-rays.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**
- ☐ **AMA 5TH EDITION**