

SENT VIA EMAIL OR FAX ON
May/02/2011

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Oxford Partial Knee Replacement vs Total Left Knee Replacement with a Three/Five Day Inpatient Length of Stay

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

Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. The injured employee went forward and hyper extended his left knee. Since that time he has had persistent pain in medial aspect of the knee going down behind the knee. Records indicate the injured employee is status post left knee arthroscopy x 2. On 04/15/10 the injured employee underwent aspiration and steroid injection of the left knee. On 10/12/10 the injured employee underwent repeat steroid injection of left knee. The notes indicate the injured employee really wanted Synvisc but it was not available, and he plans to get it done by Dr. Physical examination on 03/23/11 reported strength 5/5 in lower extremities. Reflexes were 2+ and symmetric at patella tendons and Achilles. No ligamentous laxity was appreciated on varus / valgus stressing of knee. Lachman's exam had symmetric translation with firm endpoint noted bilaterally. McMurray's exam showed no joint line tenderness to either knee. There is negative patellar grind test and no apprehension with lateral patellar subluxation. Calves are nontender and Homan's exam is negative. Range of motion testing reported left knee was 0-118 degrees. Valgus alignment of 7 degrees was noted. There was no effusion. No radiology report was submitted for review, but medial compartment degenerative joint disease with loss of joint space was noted on x-rays. Lateral joint space and PFJ have healthy joint space noted. The injured employee was recommended to undergo partial knee replacement versus total knee arthroplasty.

Utilization review determination by Dr. dated 03/30/11 indicated the proposed partial knee replacement versus total knee replacement with 5 day inpatient stay was not certified as medically necessary. Dr. noted that it was unclear the degree of arthritis in the knee based on description. Dr. further noted that it was questionable if the claimant had exhausted lower levels of care, noting there was discussion of viscosupplementation, but it was not definitive that this had been undertaken based on records provided. Guidelines would indicate total joint replacement in claimants over xx years of age. Physical examination did not report significant complaints of night pain. Moreover, a 5 day length of stay was requested, but the median stay is 3 day in what should be the aim.

A reconsideration / appeal determination by Dr. on 04/15/11 determined the request for partial knee replacement versus total knee replacement with 3-5 day inpatient stay was not certified as medically necessary. Dr. noted Official Disability Guidelines outline indications for surgery for knee arthroplasty and indicate conservative treatment such as medications and viscosupplementation or steroid injections should be attempted prior to surgery. It was noted the record makes reference to viscosupplementation, but no specific dates were given. It appeared the last steroid injection was on 10/12/10. Dr. noted objectively the indications require each 50 years or greater with body mass index of less than 35. In this case the claimant is 46 and BMI is not calculated. Previous arthroscopy from 10/30/01 indicated moderately advanced medial compartment osteoarthritis. However, noting the claimant's young age and lack of documentation of BMI, medical necessity for proposed surgical procedure could not be certified.

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

The proposed left partial knee arthroplasty versus total left knee arthroplasty with 3-5 day inpatient length of stay is not recommended as medically necessary. The injured employee sustained an injury to the left knee on xx/xx/xx and subsequently underwent left knee arthroscopy x 2. The injured employee had steroid injection x 2 with most recent injection on 10/12/10; however, there is no assessment of response. Notes also reflect the injured employee was to undergo Synvisc injections with Dr. but there is no clear documentation as to whether or not this was performed. Reference was made to radiographs of the left knee per 03/23/11 notes, but no radiology report was submitted for review. It was also noted that the injured employee is only xx years old. Per ODG guidelines, total knee replacement is not recommended for patients under the age of 50. The guidelines also indicate BMI should be less than 35. The records presented do not include the injured employee's height and weight, and therefore body mass index cannot be calculated. As such, medical necessity is not established for the proposed surgical procedure.

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)