

SENT VIA EMAIL OR FAX ON

Apr/27/2011

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/27/2011

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:

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. Records indicate the injured employee fell at work and sustained some type of twisting injury to the right knee. Physical examination on 08/04/06 reported the injured employee to be 5'9" tall and 254 pounds. Right knee exam revealed absolutely no effusion. Range of motion was 0-120 degrees plus. There was no joint line tenderness. The knee was stable to varus and valgus stresses and anterior and posterior stresses. There was negative Lachman and negative drawer. X-rays of the right knee revealed a small effusion with some early degenerative changes otherwise negative exam. MRI dated 12/28/06 revealed moderate to prominent degenerative changes involving the medial joint compartment and moderate degenerative changes involving the patellofemoral joint of the right knee. There were mild degenerative changes involved in the lateral joint compartment. Degenerative changes involving the medial meniscus with possible tear also were noted. The injured employee is status post right knee arthroscopy PMM/MFC/PFC performed 01/09/07. Office note dated 01/17/11 indicated the injured employee is working regular duty. There was pain in medial side/anterior side of the right knee. The injured employee had pain with standing/difficulty standing up. Examination revealed right knee range of motion 5-100. Knee was grossly stable. There was genuvarus deformity. There was no effusion. The injured employee was grossly neurovascularly intact. The injured employee was recommended for total knee replacement.

A request for right total knee replacement was reviewed by Dr. on 03/14/11 and Dr. determined the request to be non-certified. Dr. noted that the medical records provided were hand written and

partially legible. There was no indication that the injured employee had undergone conservative care with viscosupplementation or steroid injections. Dr. noted that although there was limited knee range of motion, there was no evidence of nighttime joint pain and no pain relief with conservative care. It was further noted that according to ODG BMI of less than 35 is recommended for total knee replacement. In this case the injured employee was noted to be obese with BMI of 37.5 as of 08/06. Current BMI was not indicated. Dr. also noted the degree of the claimant's osteoarthritis was not clear in the medical records submitted for review.

A reconsideration / appeal request for right total knee replacement was reviewed by Dr. on 04/04/11. Dr. determined the request was non-certified as medically necessary. Dr. discussed the case with Dr., and noted that Dr. confirmed the injured employee had thorough conservative treatment including medications, steroid injections, and passage of time. The injured employee also failed arthroscopic debridement. There was evidence of ongoing limited motion, pain at rest and no relief with conservative treatment. The claimant is over xx. Films reveal severe degenerative changes. The most up to date weight was reported as 254 lbs, which appears to correlate with body mass index of 37.5 which is in excess of guidelines. Dr. noted that it appears ODG guidelines are merely completely satisfied for medical necessity for total knee arthroplasty, with the only parameter not satisfied being body mass index of 37.5.

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

Based on the clinical information provided, the proposed right total knee replacement is recommended as medically necessary. The injured employee is noted to have sustained a twisting injury to the right knee on xx/xx/xx. He is status post right knee arthroscopic surgery performed on 01/09/07. The injured employee has objective evidence of multi-compartment severe degenerative changes. Records indicate the injured employee has failed extensive conservative treatment including medications, steroid injections and passage of time. The injured employee has ongoing limited motion, pain at rest, and no relief with conservative treatment. The records reflect the injured employee meets all parameters for total knee arthroplasty except the recommended body mass index of 35 or less. Given the injured employee's condition, it is unlikely he could effectively exercise in order to substantially change his body mass index prior to surgery. There are studies that indicate the rate of failure of total knee appliance up to 5 years after surgery were not influenced by injured employee's BMI except subjects affected by morbid obesity. Noting this is a recommendation and not an absolute requirement, and noting there is evidence that obese patients fair nearly as well as normal weight after total knee arthroplasty, the proposed surgical procedure is indicated as medically necessary.

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 KNOWLEDGBASE
- 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)