The DYLL REVIEW
We take the worry out of Peer Reviews
25 Highland Park Village #100-177 Dallas TX 75205
Phone: 888-950-4333 Fax: 888-9504-443

Notice of Independent Review Decision

DATE OF REVIEW: 5/16/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Total Left Knee Arthroplasty and indicated procedure with input stay CPT-27447

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota

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.

Upon independent review, I find that the previous adverse determination should be upheld.

Based on evidence-based medicine and *Official Disability Guidelines (ODG Knee and Leg Chapter: Knee Arthroplasty, and Length of Stay; ODG indications for Surgery: Knee Arthroplasty, Criteria for Knee Joint Replacement)*, the purposed surgery is not considered medically indicated or necessary at this time. The patient's BMI is reported to be in excess of 40, which exceeds the *Official Disability Guidelines*. Additionally, there is no evidence of limited range of motion, and the patient's young age also do not support this procedure.

Based on the above guidelines, the proposed left total knee arthroplasty and indicated procedures with the three- to four-day length of stay are not recommended

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work-related injury to the left knee. There had been a previous left knee arthroscopy with meniscectomy done on 11/01/10 prior to the date of injury. The injury date was xx/xx/xx when the patient slipped and fell landing on his left knee. Since that time, the patient has had conservative treatment including anti-inflammatory medications, viscosupplementation, and bracing.

An MRI was performed on 01/17/11 which showed what would be consistent with postoperative changes including truncation of the body and posterior horn of the medial meniscus but without apparent recurrent tear of the meniscus. There was noted to be chondromalacial changes in the medial weightbearing articular surface of the medial femoral condyle along with prominent bone marrow edema. Chondromalacia was also seen in the lateral femoral condyle and medial tibial plateau as well as the patellofemoral compartment.

X-rays performed by Dr. on 03/11/11 revealed some narrowing of the medial joint space without obvious osteophyte formation. Examination findings revealed excellent range of motion with tenderness along the medial joint line and a mild effusion.

Again, there had been conservative care, which included oral anti-inflammatory medications, steroid injections, physical therapy, bracing, and viscosupplementation.

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

Based on evidence-based medicine and *Official Disability Guidelines (ODG Knee and Leg Chapter: Knee Arthroplasty, and Length of Stay; ODG indications for Surgery: Knee Arthroplasty, Criteria for Knee Joint Replacement)*, the purposed surgery is not considered medically indicated or necessary at this time. The patient's BMI is reported to be in excess of 40, which exceeds the *Official Disability Guidelines*. Additionally, there is no evidence of limited range of motion, and the patient's young age also do not support this procedure.

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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)