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Notice of Independent Review Decision

DATE OF REVIEW: 10/27/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left total knee replacement and arthroscopy with three day inpatient stay

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:

X 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.

Left total knee replacement and arthroscopy with three day inpatient stay - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY

The Employee First Report of Injury stated the patient. She stated her neck was sore, as was part of her back. She also said her left knee felt like it had lots of pressure. On 08/08/11, the claimant complained of recurrent pain and swelling primarily noted in her left knee. She had gone to the emergency room on 07/30/11 due to the pain and swelling. She was treated with a steroid injection, Tramadol, and Etodolac. The claimant was noted to be ready to take the step to a total knee arthroplasty. On 09/26/11, it was noted the patient's pain level was 9/10 constantly when she stood. She had received multiple injections without relief and she was wearing an unloader brace. It was also noted she was taking non-steroidal anti-inflammatories that had damaged her kidneys. The assessments were bilateral effusion of the lower leg joint and bilateral osteoarthritis, worse on the left than the right, not responsive to treatment. A total knee arthroplasty on the left was recommended. Dr. requested preauthorization from IMO for a left total knee replacement. The date of the request was not provided, but it was received on 09/06/11. On 09/22/11, an amended adverse determination letter was provided by Dr. with, non-authorizing the requested left total knee replacement, arthroscopy, and a three day inpatient stay. On 09/22/11, received another preauthorization request from Dr. for a left total knee replacement. On 09/30/11, Dr. with also provided an adverse determination for the left total knee replacement, arthroscopy, and three day inpatient stay. On 10/04/11, the claimant called and informed Dr. that the insurance thought her BMI was too high and that was why they were not approving surgery. It was noted her vitals has been corrected, as they were entered incorrectly at the last visit. She had pain 24 hours a day, including pain that interfered with her sleep. It was noted, during the phone call, the claimant stated, "She was almost suicidal over the waiting process for this to be approved and is crying in pain throughout most of the day with pain." Dr. again recommended a total knee replacement, as her arthritis was in both anterior and medial compartments and he did not feel a partial replacement was a good option for the patient. It was felt the total knee replacement was the next logical step.

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

There was limited documentation provided for review. However, the 08/08/11 evaluation from Mr. stated there was generalized swelling and tenderness about the left knee. Active flexion and extension were full, but painful and without crepitance. There was no valgus or varus instability present and strength was 5/5. X-rays of the left knee markedly osteoarthritic changes present-medial anterior. These films were done some four months status post original injury. On 09/26/11, active flexion and extension lacked 10 degrees with pain at the extremes without crepitance. There was moderate valgus instability present and strength was 5/5. The x-rays were essentially unchanged. Her examination was unchanged on 10/04/11. The Official Disability Guidelines (ODG) indications for knee arthroplasty include conservative care. Based on the documentation provided for review, it is not clear if the claimant has exhausted all conservative care, including steroid injections and physical therapy. The subjective clinical findings include limited range of motion, which the claimant, as of 09/26/11 and 10/04/11, only lacked 10 degrees of full range of motion. The objective clinical findings are an age over 50 years, which the claimant is 49 at this time, and a Body Mass Index of less than 35. According to the documentation, the claimant is overweight, but the exact BMI is not clear. The adverse determination letter of 09/30/11 stated her BMI is 39.1. However, Dr. 10/04/11 note indicate her vitals were incorrectly entered, so her actual BMI is unclear, as her weight and height are only documented on the 10/04/11 note. Therefore, in my opinion, the requested left total knee arthroplasty and arthroscopy with a three day inpatient stay is not reasonable or necessary. The previous adverse determinations should be upheld at this time.

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 AND KNOWLEDGE BASE**
- ☐ **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**

X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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)**