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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Total Knee Replacement; 3-4 day inpatient stay

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

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

OD Guidelines

Request for IRO dated 09/20/11

Utilization review determination dated 08/19/11

Utilization review determination dated 08/29/11

Clinical records Dr. dated 03/25/10

MRI right knee 08/25/10

Operative report dated 04/08/10

Radiographic reports

Clinical records Dr. dated 07/26/10-08/17/11

EMG/NCV dated 05/02/11

MRI right knee dated 05/28/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xxxx. On this date he is reported to have sustained a tibial plateau fracture. He was subsequently seen by Dr. This study notes abutted fragment seen in posterior tibial medially and posterior PCL attachment. Fluid signal surrounds the defect which shows some sclerotic margins indicating ununited nondisplaced fracture. Surrounding edema is also seen in tibial plateau fracture. The claimant was subsequently taken to surgery on 04/08/10 at which time he underwent arthroscopic partial medial and lateral meniscectomies and right knee synovectomy.

On 07/26/10 the claimant came under the care of Dr. The claimant reported no improvement with surgery. His present complaint is right knee pain. On physical examination he has mild

medial laxity and 30 degrees of flexion grade I questionably positive anterior and posterior drawer test, negative McMurray's, negative Lachman's, no laxity and full extension. Radiographs show mild medial joint space narrowing. MRI is reported to have revealed large radial tears of body of posterior horn and severe truncation, a 1.7 cm bony fragment in posterior aspect of tibial plateau at insertion of PCL, there is non-united avulsion fracture, moderate patellar chondromalacia affecting the superior lateral aspect of patella. The claimant was recommended to undergo repeat arthroscopy. Records indicate the claimant was returned to surgery on 12/09/10 at which time a partial resection of anterior horn of medial meniscus was performed as well as chondroplasty of the medial femoral condyle. Postoperatively the claimant was referred for physical therapy. On 04/18/11 it is reported the claimant's knee hurts all the time. He has constant pain. He was opined for social security disability. He said he has 18 million burning sensation of the entire medial aspect of right leg. He reported it is difficult to walk. His physical examination is unremarkable. The claimant was subsequently recommended to undergo Synvisc injections to right knee which were initiated on 07/19/11. The claimant had no improvement with this and subsequently was recommended to undergo total knee arthroplasty. Clinic note dated 08/15/11 notes the claimant had an old posterior cruciate ligament rupture which apparently was present prior to the date of injury. The claimant had residual flexion contracture as result of that. He does have medial femoral condylar problem associated with most recent injury. Dr. notes the claimant will most likely require partial knee replacement. The record contains EMG/NCV study dated 05/02/11 which showed no evidence of lower extremity radiculopathy or peripheral neuropathy. Repeat MRI of the knee performed on 05/27/11 indicates an avulsion fracture of tibial attachment of PCL, associated marrow edema suggesting the fracture is likely not acute / chronic. There is subchondral erosion at the lateral patellar articular facet with loss of some overlying articular cartilage consistent with chondromalacia. The posterior horn of the medial meniscus appears grossly diminutive. There is residual horizontal oblique signal within the posterior horn of the medial meniscus. There is intrasubstance mucoid degeneration of lateral meniscus.

The initial request was reviewed on 08/19/11 by Dr. Dr. non-certified the request noting that the claimant has full range of motion of the right knee with no medial or lateral laxity, full extension, negative Lachman's, negative anterior and posterior drawer. He notes pharmacologic treatment has not been optimized. Radiographs of the right knee were reported to show no evidence suggestive of osteoarthritis. He notes the patient's weight and height were not provided to determine BMI. As such, the request was non-certified.

A subsequent appeal request was reviewed on 08/29/11 by Dr. Dr. non-certified the request noting there was adverse determination of the previous review. He notes previous non-certification noted lack of documentation, failure of conservative treatment, x-ray showing evidence of osteoarthritis and BMI. He notes treatment has included Synvisc and physical therapy; however, there was no clear documentation that at least 2 of the 3 compartments are affected. There is no data regarding BMI.

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

The request for right total knee replacement with 3-4 day inpatient stay is not supported by the submitted clinical information. The available medical records indicate the claimant sustained an injury to his knee as result of work related activity. He subsequently has undergone two operative interventions and continues to have significant right knee pain. The records indicate the claimant has been treated with oral medications, physical therapy, and Synvisc injections without reported relief. The record does not substantially detail the claimant's response to these interventions other than he has not improved. Further, the record does not include any imaging studies which would indicate that two of the three compartments are affected. The claimant is noted to have medial joint space narrowing and noted to have loss of joint space consistent with unicompartmental disease. The record does not contain any data regarding the claimant's height and weight to establish BMI. Based on the clinical information provided, the claimant does not meet criteria per ODG, and therefore, the previous utilization review determinations are upheld.

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)