

# CASEREVIEW

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Notice of Independent Review Decision

**DATE OF REVIEW:** September 7, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Inpatient surgery right TKA.

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

2/16/11: M.D. evaluated the claimant. PE: There is medial joint line tenderness to palpation. There is positive patellofemoral compression test and with crepitus. There is a negative Lachman exam. X-Rays: Osteoarthritic changes in the medial compartment with joint space narrowing and sclerosis and early osteophytes formation.

3/18/11: Supartz injection was performed.

3/25/11: Supartz injection was performed.

4/1/11: Supartz injection was performed.

4/8/11: Supartz injection was performed.

4/15/11: Supartz injection was performed.

6/10/11: M.D. re-evaluated the claimant.

7/8/11: M.D. re-evaluated the claimant.

7/20/11: M.D. performed an UR on the claimant.

8/8/11: M.D. performed an UR on the claimant.

### **PATIENT CLINICAL HISTORY:**

The claimant is a male, Height 5'11" and Weight 300 pounds.

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

The previous decisions are upheld. There is no documentation of limited ROM and the claimant has a BMI over 40. Based on the above mentioned the claimant does not meet the ODG Criteria for a total knee replacement.

### **ODG:**

#### **ODG Indications for Surgery™ -- Knee arthroplasty:**

**Criteria** for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement may be considered. If 2 of the 3 compartments are affected, a total joint replacement is indicated.):

**1. Conservative Care:** Medications. AND (Visco supplementation injections OR Steroid injection). PLUS

**2. Subjective Clinical Findings:** Limited range of motion. AND Nighttime joint pain. AND No pain relief with conservative care. PLUS

**3. Objective Clinical Findings:** Over 50 years of age AND Body Mass Index of less than 35, where increased BMI poses elevated risks for post-op complications. PLUS

**4. Imaging Clinical Findings:** Osteoarthritis on: Standing x-ray. OR Arthroscopy.

([Washington, 2003](#)) ([Sheng, 2004](#)) ([Saleh, 2002](#)) ([Callahan, 1995](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).

See also [Skilled nursing facility LOS](#) (SNF)

**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)