

US Resolutions Inc.

An Independent Review Organization
3267 Bee Caves Rd, PMB 107-93
Austin, TX 78746
Phone: (361) 226-1976
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: hemiarthroplasty of left knee

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

M.D., 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

Official Disability Guidelines

Request for IRO dated 05/23/12

Utilization review determination dated 04/16/12

Utilization review determination dated 05/15/12

MRI left knee dated 12/22/10

Clinical records Dr. dated 01/18/11-05/07/12

Operative report dated 01/27/11

Physical therapy treatment records

Letter Dr. dated 07/25/11

Texas Department of Insurance Decision and Order dated 11/28/11

CT of knee dated 03/13/12

Letter Dr. dated 04/17/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained injuries to left knee on xx/xx/xx. He apparently stepped into a hole. MRI of left knee dated xx/xx/xx notes tricompartmental degenerative changes with moderate chondromalacia, evidence of anterior cruciate ligament strain, and thickening of posterior cruciate ligament, chronic tear with maceration of body of lateral meniscus and complex tear of posterior horn of lateral meniscus, posterior horn of medial meniscus extending into body and inferior surface, mild subchondral edema in lateral femoral condyle. The claimant had surgery on 01/27/11 at which time he underwent arthroscopy with partial lateral meniscectomy, chondroplasty of lateral compartment of left knee. The claimant was referred for postoperative physical therapy and noted to have difficult postoperative course with continued pain. On 07/25/11 Dr. recommends the claimant undergo lateral compartment hemiarthroplasty. Records indicate on 11/28/11 the claimant went to benefit review conference which found that extent of injury included tricompartmental

degenerative changes with moderate chondromalacia of left knee. Records indicate the claimant was maintained on oral medications. On 01/30/12 he was recommended to undergo lateral compartment arthroplasty. His conservative treatment included medications, injections and bracing without help. On physical examination he is noted to have severe tenderness around the lateral aspect, bone on bone crepitus, and limitations in range of motion of left knee, and unstable lateral collateral ligament with varus stressing of the knee. He is noted to be genu valgum. He was referred for CT of knee on 01/13/12. This study notes a prior right knee ACL repair with interference, screws in good position. The left knee bones are osteoporotic. There are severe tricompartmental degenerative changes, osteophytes of distal end. Record includes letter from Dr. dated 04/17/12. It is noted the claimant has exhausted all conservative treatment and has previously undergone arthroscopic surgery, which notes extensive chondral damage and torn lateral meniscus. He has now developed severe posttraumatic lateral compartment arthritis. He is noted to be bone on bone on x-ray. He has severe instability of lateral collateral ligament and severe valgus deformity. Lateral compartment hemiarthroplasty is recommended. The most recent clinic note dated 05/07/12 notes no substantive changes in claimant's physical examination.

The initial review was performed by Dr. on 04/16/12. Dr. non-certified the request noting that the claimant's age is 45 and there was no rationale for proceeding to arthroplasty at this time in this young claimant. He therefore finds the request not to be supported as medically necessary. The appeal request was reviewed by Dr. on 05/15/12. Dr. non-certified the request noting that the previous non-certification was due to the age of the claimant and lack of documentation of objective findings and rationale. He notes a limited physical examination and that the records provided failed to document the exhaustion of other recommended conservative treatments. He notes that there were no physical therapy progress notes to document the response to therapy or to prior injections. BMI was not provided.

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

This claimant sustained injury to his knee after stepping in a hole on xx/xx/xx. Initial imaging studies indicated severe tricompartmental osteoarthritis. The claimant was taken to surgery at which time he underwent an arthroscopic lateral meniscectomy and a chondroplasty of the lateral compartment. He failed to improve post-operatively and had continued elevated levels of pain. He went to BRC on 11/28/11. The decision and order finds the tricompartmental osteoarthritis to be included as part of the compensable injury. The records clearly establish that the claimant failed conservative management and is a surgical candidate. However, the requested hemiarthroplasty is not medically necessary as it will not address the extensive pathology noted in all three compartments. The performance of a hemiarthroplasty will ultimately result in a conversion to a total knee arthroplasty and therefore there is no potential benefit to the performance of this procedure and medical necessity is not established. Therefore, the reviewer finds medical necessity is not established for the requested hemiarthroplasty of left knee.

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)