

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/22/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
inpatient right total knee arthroplasty

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon (Joint)

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 medical necessity exists for each health care service in dispute. The reviewer finds that medical necessity does not exist for inpatient right total knee arthroplasty.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy notes from Orthopedic Surgery Group dated 02/23/01 – 04/20/11
Clinical notes from Orthopedic Surgery Group dated 10/23/00 – 10/22/01
Physical therapy notes from Orthopedic Surgery Group 03/27/12 – 04/06/12
Operative report dated 11/16/00
Clinical notes from Dr. dated 03/20/12 – 08/31/12
Prior review dated 08/22/12 and 09/19/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury xx/xx/xx. The patient is status post arthroscopic debridement of the medial femoral condyle and lateral tibial plateau with microfracture and chondroplasty performed on 11/16/00. The patient is noted to have undergone postoperative physical therapy after this procedure. The patient was seen by Dr. in 03/12 with complaints of recurrent right knee pain. The patient did report problems with activities and had difficulty climbing stairs. Physical examination revealed some loss of flexion in the right knee. Crepitation at the patella was present. Radiographs were stated to show narrowing of the patellofemoral space to the right as compared to the left. The patient underwent a steroid injection to the right knee on 03/20/12 and the patient was prescribed Naprelan and referred for physical therapy. The patient continued physical therapy through 04/12. Follow-up on 05/01/12 with Dr. indicated that the patient did have some benefits from cortisone injections. Physical examination revealed improved tenderness of the right knee

with continued crepitation over the right patella. Full range of motion was present. Follow-up on 07/24/12 indicated that the patient had undergone at least 3 cortisone injections at this point in time. Physical examination revealed tenderness over the lateral joint line in the right knee. No instability was present. Radiographs demonstrated evidence of lateral compartment narrowing with degenerative changes. The request for right total knee arthroplasty was denied by utilization review on 08/22/12 as there was no documentation regarding a recent BMI for the patient. The request was again denied by utilization review on 09/19/12 as BMI for the patient was not available and there was no documentation regarding exhaustion of viscosupplementation injections.

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

The documentation does indicate that the patient has well-maintained joint spaces other than the patellofemoral space. No actual radiograph reports were provided for review indicating joint space narrowing in any other compartments of the right knee. Although the patient has undergone cortisone injections and physical therapy, there is no documentation that the patient reasonably exhausted viscosupplementation injections as recommended by current evidence based guidelines. Additionally, no current height and weight measurements were provided for review to allow a determination of BMI as indicated by guidelines. The clinical documentation provided for review does not meet guideline recommendations for the requested service. The reviewer finds that medical necessity does not exist for inpatient right total knee arthroplasty.

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)