

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient 3 day right knee medical hemiarthroplasty

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes 03/15/13-05/29/13

Radiographs right knee 03/18/13

MRI right knee 03/27/13

Prospective review into response 07/25/13

Prior review 06/28/13 and 07/22/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a patellar fracture on xx/xx/xx. Radiographs of the right knee on 03/13/13 showed retained screw within the patella and linear lucency through the upper and outer patella. Clinical record from 03/15/13 indicated that the patient was utilizing hydrocodone, gabapentin, Flexeril, ibuprofen, and Prilosec. The patient reported moderate to severe pain in the right knee with associated weakness, numbness, catching, locking, popping, and instability. Physical examination at this visit demonstrated limited range of motion in the right knee to 100 degrees flexion with a 10 degree extension lag. There was no tolerance to provocative testing and mild weakness on flexion and extension. There was some hyperesthesia to touch at the medial right knee. Clinical record indicated that the patient had a previous osteochondral graft in 01/12 and there were findings concerning for possible RSD. MRI of the right knee on 03/27/13 showed a full thickness cartilage defect in the weight bearing portion of the medial femoral condyle and in the anterior tibial plateau. In reviewing the study of prior studies there was progression of a chondromalacia and chondral loss in the medial compartment of the left knee and right knee. Clinical evaluation on

05/29/13 indicated that the patient continued to have pain and discomfort in the right knee along the medial aspect with locking and instability. Physical examination demonstrated varus and valgus stability with tenderness along the medial joint line. There was crepitus on range of motion. The patient was recommended for medial hemiarthroplasty due to failure of conservative intervention. The request for a right knee medial hemiarthroplasty with three day inpatient stay was denied by utilization review on 06/20/13 as there was no documented loss of range of motion in the right knee without as well as lack of evidence regarding narrowing of the medial joint space. The request was again denied by utilization review on 07/22/13 as there was no evidence of chondral loss or compartment space narrowing medially to support a unicompartmental arthroplasty.

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

The patient has been continuing to report severe right knee pain medially despite multiple surgical interventions. The patient has not progressed with further conservative treatment although it is unclear what has been provided to the patient to date other than medication management. There was no imaging evidence of significant joint space loss medially consistent with osteoarthritis. The patient has intact menisci and there was no evidence of malalignment in the knee. Given the absence of clear imaging evidence of osteoarthritic joint space narrowing, sclerosis formation, or spurring in the medial joint space of the right knee; it is the opinion of this reviewer that the proposed right knee hemiarthroplasty medially would not be supported as medically necessary based on guideline recommendations. As such the three day inpatient stay request is also not supported as medically necessary at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES