

C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/31/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: inpatient left knee TKA 3-5 days

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

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. It is the opinion of the reviewer that the request for an inpatient left knee TKA 3-5 days is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI of the left knee dated 05/06/13

Clinical note dated 05/21/13

Previous utilization reviews dated 05/29/13 & 07/09/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his left knee. The MRI of the left knee dated 05/06/13 revealed a medial meniscus tear as well as an ACL tear. Joint effusion was noted throughout the left knee. A bony contusion was also noted at the medial tibial plateau. A bony lesion was noted at the lateral tibial plateau as well. A 2.9 x 1.1cm hematoma was additionally noted anterior to the patellar ligament. The clinical note dated 05/21/13 details the patient stating the initial injury occurred when he was hanging a door and twisted his leg. The patient stated that he felt immediate onset of pain on xx/xx/xx. The note does detail the patient experiencing locking, catching, and a giving way sensation. The note does detail the patient having previously undergone a left knee arthroscopy at the left knee several years prior to the office visit. The patient's past surgical history is significant for 3 total knee arthroplasties on the right and an arthroscopy on the left. The patient's height is noted to be 6 feet 1 inches tall and he currently weighs 314 lbs. The patient was noted to have good range of motion at both knees with flexion and extension. The patient was noted to have a positive McMurray's sign at the left knee. The patient was also noted to have positive joint line pain.

The previous utilization review dated 05/29/13 in regards to the request for a left knee TKA resulted in a denial as the patient's BMI is noted to be in excess of 35.0. Additionally, the previous records indicated the patient having peripheral vascular problems with significant lymphedema in both lower extremities.

The previous utilization review dated 07/09/13 for a left TKA resulted in a denial secondary to the patient's BMI exceeding the guideline recommendations of 35.0 as well as the ongoing peripheral vascular problems.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of left knee pain. The Official Disability Guidelines recommend a total knee arthroplasty provided the patient meets specific criteria to include a BMI of less than 35.0 and no contraindications exist regarding any surgical interventions. The patient is noted to be 6 feet 1 inches tall and currently weighs 314 lbs. which reveals a BMI of 41.0. Additionally, the clinical notes do detail the patient having ongoing peripheral vascular issues. Given the patient's BMI in excess of the guideline recommendations at 35.0 and taking into account the noted contraindication to any surgical intervention, this request is not indicated. As such, it is the opinion of the reviewer that the request for an inpatient left knee TKA 3-5 days is not recommended as medically necessary.

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)