

MEDRx

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Notice of Independent Review Decision

DATE OF REVIEW: 7/2/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of total left knee replacement.

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

The reviewer is a Medical Doctor who is board certified in orthopedic.

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)

The reviewer agrees with the previous adverse determination regarding the total left knee replacement.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from URA

Medical Exam

2/5/2013

Progress Record

7/29/2010-4/11/2013

Evaluation- 6/24/2010
Discharge- 7/23/2010
X-Ray Reports
5/10/2010, 6/26/2012, 2/5/2013
MRI Report
5/21/2010
OR Report
6/1/2010
Appeal Request 6/5/2013
Appeal Peer Report 6/11/2013
Appeal Determination Letter 6/12/2013
Initial Peer Report 5/20/2013
Initial Determination Report 5/20/2013
LHL009 Form 6/14/2013

Records reviewed
Medication Record 6/3/2010-7/7/2011
5/27/2010
5/27/2010

A copy of the ODG was provided by the URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Summary: The patient is s/p a left knee arthroscopic partial medial meniscectomy in 6/2010. This was as treatment for an apparent workplace-associated internal knee injury of mensical tear. The claimant had stepped in a hole at work, resulting in the injury. The AP documented post-traumatic arthritis of the knee having developed. Treatments have included medications, restricted activities, PT and cortisone injections. The claimant was noted to continue with severe knee pain (including at night) as of 6/4/13. The claimant was noted to be 5'6" with a weight of 264 lbs. Knee motion was from 15 to 105 degrees of flexion. The knee was stable to stress and exhibited crepitus. Genu varum was noted. "End stage" and "tricompartmental" knee arthrosis was noted on imaging. Denial letters noted the lack of recent comprehensive non-operative treatments including weight reduction, along with age under 50 years old

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

With the claimant's age under xx, calculated BMI of 42.6 and lack of recent and comprehensive non-operative treatment protocol specifically including weight-reduction trial and failure; the requested procedure is not reasonable and medically necessary at this time. Guideline criteria referenced below have not been met as the claimant's age and he has an elevated BMI of greater than 35. Based on the lack of guidelines having been met, the denial rationale is hereby reaffirmed.

Reference: ODG Knee Chapter

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: Exercise therapy (supervised PT and/or home rehab exercises). AND Medications. (unless contraindicated: NSAIDs OR Visco supplementation injections OR Steroid injection). PLUS

2. Subjective Clinical Findings: Limited range of motion (<90° for TKR). AND Nighttime joint pain. AND No pain relief with conservative care (as above) AND Documentation of current functional limitations demonstrating necessity of intervention. 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 (documenting significant loss of chondral clear space in at least one of the three compartments, with varus or valgus deformity an indication with additional strength). OR Previous arthroscopy (documenting advanced chondral erosion or exposed bone, especially if bipolar chondral defects are noted). ([Washington, 2003](#)) ([Sheng, 2004](#)) ([Saleh, 2002](#)) ([Callahan, 1995](#))

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)