

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/02/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 27466 left medial unicompartmental arthroplasty, 3 days inpatient stay

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 this reviewer's opinion that medical necessity would not be established for the 27466 left medial unicompartmental arthroplasty, 3 days inpatient stay

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI right knee 02/03/09

MRI left knee 10/20/10 and 01/17/11

Clinical record 04/19/13

Prior reviews 05/01/13 and 05/29/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. Prior MRI of the left knee from 2010 in October demonstrated mild to moderate osteoarthritic changes in both the medial and lateral joint compartments. The most recent MRI of the left knee from 01/17/11 demonstrated grade 3 to 4 chondromalacia in the weight bearing articular aspect with grade 2 to 4 chondromalacia in the medial tibial plateau and grade 2 chondromalacia in the lateral femoral condyle. Clinical record on 04/19/13 stated that the patient continued to have left knee pain despite the use of narcotics or benzodiazepines. Physical examination demonstrated pain free range of motion in the hips. There was medial joint line tenderness with no mild suprapatellar effusion. There was decreased range of motion secondary to pain both actively and passively. The patient was recommended for a medial unicompartmental arthroplasty. The request for left medial unicompartmental arthroplasty was denied by utilization review on 05/01/13 as there were multiple osteoarthritic changes in all the compartments of the left knee. There was also no documentation regarding all conservative treatments or current BMI. The request was again denied by utilization review on 05/29/13 as there was extensive osteoarthritis throughout the left knee and the patient would most likely require a knee arthroplasty in the future.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been continuing with left knee pain with loss of range of motion secondary to osteoarthritis throughout the left knee.

The most recent evaluation on 04/19/13 did not identify current BMI. It was also unclear what conservative treatment had been exhausted to date. Given the clear evidence of multicompartamental osteoarthritis in the left knee a unicompartmental knee arthroplasty would not be medically necessary per guideline recommendations. In all reasonable medical probability the patient would require a future total knee arthroplasty due to the extent of the osteoarthritis throughout the left knee. Clinical documentation also does not address other concerns noted in prior reviews including current BMI or any prior conservative treatment for the left knee. As the clinical documentation submitted for review does not meet guideline recommendations for the requested service, it is this reviewer's opinion that medical necessity would not be established for the 27466 left medial unicompartmental arthroplasty, 3 days inpatient stay and the prior denials are upheld.

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)