

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/16/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

3 day inpatient LOS with Right Total Knee Replacement

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 dated 07/18/12 – 03/20/13

MRI of the right knee dated 05/11/12

Previous utilization reviews dated 03/04/13 & 04/03/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his right knee. The MRI of the right knee dated 05/11/12 revealed arthritic changes noted at the medial compartment of the knee with a complex tear involving the posterior horn and body of the medial meniscus. Mild fissuring was noted at the medial facet patella articular cartilage. The patient was also noted to have a small Baker's cyst. The clinical note dated 07/18/12 details the patient stating the initial injury occurred when he stepped on a rock and twisted his knee. The patient was noted to have complaints of increased pain, swelling, and popping. The patient was noted to have previously undergone an arthroscopic partial meniscectomy. No significant benefit was noted following the surgery. The patient was noted to have an increase in pain with all weight bearing activities. The note does detail the patient having undergone x-rays which revealed significant degenerative changes noted within the joint space narrowing of the medial compartment and the patella femoral compartment as well. The clinical note dated 08/27/12 details the patient undergoing an injection which did provide approximately 1 week of relief. However, the patient continued with complaints of pain with weight bearing. The clinical note dated 03/20/13 details the patient being recommended for a right total knee arthroplasty.

The previous utilization review dated 03/04/13 resulted in a denial for a right knee total arthroplasty secondary to the lack of information regarding the patient's outcome of the previous injection. Additionally, no information was submitted regarding the patient's BMI.

The previous utilization review dated 04/03/13 resulted in a denial for a total knee arthroplasty secondary to a lack of information regarding the patient's exhaustion of lower levels of care as well as injection therapy. Furthermore, no information was submitted regarding the patient's current BMI.

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 right knee pain. A knee arthroplasty would be indicated provided the patient meets specific criteria to include completion of all conservative treatments as well as significant clinical findings noted by exam. The patient is noted to have previously undergone an injection; however, no information was submitted regarding the patient's conservative treatments or medications. Furthermore, the patient's current BMI status was not provided. Given that no information was submitted regarding the patient's completion of all conservative measures and taking into account that no information was submitted regarding the patient's current BMI status, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that the request for a total right knee arthroplasty with a 3 day length of stay is recommended as not 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)