

Notice of Independent Review Decision

**DATE OF REVIEW: 11/11/2014**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Left total knee arthroplasty

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the left total knee arthroplasty is not medically necessary to treat this patient's condition.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury to the left knee that had already been injured earlier. She has undergone surgical procedures including ACL repair on two occasions, the earliest being 1981. She has received intra-articular corticosteroid injections and visco supplementation. She has had a past history of osteoarthritis of the right knee leading to a total knee arthroplasty of the right knee. Internal derangement of the left knee is a pre-existing pathological condition to the giving way episode of 1995.

Current physical findings include varus alignment of the left knee with flexion of 120 degrees with 5 degrees of hyperextension. There is no ligamentous instability documented as confirmed by CT scan. The specifics of disability related directly to the left knee are not documented. The request to preauthorize a total knee arthroplasty has been considered and denied; reconsidered and denied.

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

The medical record documentation along with the request to approve a surgical preauthorization for a left total knee arthroplasty does not include a description of disability. The patient is described as "active". Her employer and job description are not provided. Her range of motion is from 5 degrees hyperextension to 120 degrees of flexion. Patellofemoral joint crepitation is documented and subpatellar catching is described. Her primary symptom is pain unrelieved by NSAID medication or intra-articular corticosteroid and hyaluronic acid injections. There is no mention of bracing or activity modification. The patient is relatively young and is very active. The prior denials of this surgical preauthorization request were appropriate and should be upheld.

**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)