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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/08/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right total knee arthroplasty

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

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 this reviewer that the request for a right total knee arthroplasty is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her right knee. The operative note dated 03/24/09 indicates the patient undergoing an arthroscopic partial medial meniscectomy with a chondroplasty, ACL reconstruction, and a PRP tissue graft insertion. The clinical note dated 03/26/12 indicates the patient continuing with complaints of right knee pain. The patient stated the pain awakened her and was affecting her sleep. The patient stated that she was having difficulty climbing and descending stairs. The note indicates the patient having undergone a Synvisc injection in May of 2011 which did provide some relief. Upon exam, the patient was able to demonstrate 3-130 degrees of range of motion. A positive Lachman's sign was identified. The patient also had crepitus throughout the right knee. The clinical note dated 08/12/13 indicates the patient wearing a knee sleeve periodically. The note confirms the patient having undergone 3 previous injections at the right knee. Swelling was identified along with buckling. The note indicates the patient undergoing an injection at that time. The clinical note dated 10/29/13 indicates the patient continuing with complaints of medial sided joint pain. The patient stated that ambulating was exacerbating her pain. The patient continued with 3-130 degrees of range of motion along with crepitus throughout the knee. The peer review dated 11/06/13 indicates the patient having completed a full course of conservative therapy between September of 2008 through September of 2009. The patient reported swelling with buckling at the right knee at that time.

The clinical note dated 02/07/14 indicates the initial injury occurring when she had a fall while at work. The patient felt a pop with immediate sharp pain. The patient has undergone therapy as well as the steroid injections with no significant benefit. The note indicates the patient able to demonstrate 0-145 degrees of range of motion actively with 12-145 degrees of range of motion passively. No strength deficits were identified. The note indicates the

patient having undergone x-rays of the right knee which revealed severe tricompartmental degenerative joint disease with bony apposition at the medial compartment. Lateral tracking was also identified at the patella.

The utilization review dated 02/14/14 resulted in a denial as no information was submitted regarding the patient's use of non-steroidal anti-inflammatory medications and the patient was identified as having full range of motion at the affected knee. The utilization review dated 02/25/14 resulted in a denial for a knee arthroplasty as no range of motion deficits were identified at the right knee.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient having ongoing complaints of right knee pain. A knee arthroplasty would be indicated provided the patient meets specific criteria to include significant range of motion limitations confirmed by clinical exam to include an inability to flex the knee beyond 90 degrees. The patient is able to actively demonstrate 0-145 degrees of range of motion at the right knee. Given that the patient has no significant range of motion deficits at the right knee, this request is not indicated. As such, it is the opinion of this reviewer that the request for a right total knee arthroplasty 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)