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DATE NOTICE SENT TO ALL PARTIES: Apr/22/2016

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: DO 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 the request for left total knee arthroplasty is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male. On XX/XX/XX, the patient was seen in clinic. It was noted he had received trauma to multiple body parts including the elbow, pelvis and right lower extremity. He also had left knee pain. His primary care physician had ordered x-rays which apparently showed severe knee arthritis, and on exam, his knee had tenderness to palpation throughout. He had no ligament instability. He had full extension and flexed to greater than 100 degrees. X-rays showed near bone on bone changes in the medial compartment of the left knee. An ultrasound guided injection was recommended and performed. On XX/XX/XX, the patient returned to clinic. He noted increased pain in his left knee. As he had near bone on bone to the medial compartment, a total knee arthroplasty was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review report for the requested left knee arthroplasty utilized Official Disability Guidelines knee chapter. It was noted the official report of imaging was not submitted for verification. Therefore the request was non-certified.

On XX/XX/XX, a utilization review report on appeal, for total knee arthroplasty, with navigation, cited Official Disability Guidelines knee chapter, and stated that while there was an indication for total knee arthroplasty, the request included navigation. Navigation was not recommended as there was inadequate data to permit scientific conclusions.

There were no exceptional factors presented to support the medical necessity of computer assisted navigation in the absence of guideline support. A peer to peer contact was not established to modify the treatment plan. The request therefore was non-certified.

This reviewer is using Official Disability Guidelines knee and leg chapter, which indicate that robotic assisted knee arthroplasty is not recommended based on the body of evidence for medical outcomes, and there is insufficient evidence to conclude that orthopedic robotic assisted surgical procedures provide comparable or better outcomes to conventional open or

minimally invasive surgical procedures. It is important to note that this request is for a left total knee arthroplasty without mention of a need for navigation assistance. In regards to the total knee arthroplasty, the guidelines state that conservative measures should be documented, including exercise and medications, there should be limited range of motion less than 90 degrees for total knee arthroplasty, and osteoarthritis should be demonstrated on imaging studies in at least one of three compartments with varus or valgus deformity in indication with additional strength. Official x-rays have not been provided. There is paucity of information regarding recent attempts at conservative care. The most recent progress note dated XX/XX/XX, does not indicate functional deficits with decreased range of motion less than 90 degrees.

It is the opinion of this reviewer the request for left total knee arthroplasty is not medically necessary 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)