

MEDICAL CONTESTED CASE HEARING NO. 11044
M6-10-29259-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A contested case hearing was held on October 18, 2010, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that a right total knee arthroplasty is not reasonably required health care for the compensable injury of _____?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by PA, ombudsman. Respondent/Carrier appeared and was represented by JF, attorney. The employer representative was BJ.

BACKGROUND INFORMATION

Claimant injured her right knee as she stepped off a curb while leaving work on _____. She was seen at the emergency room where x-rays were taken. No fracture was noted and Claimant was given a knee immobilizer, crutches, and anti-inflammatory medications. She then saw the company doctor who recommended an MRI. Since he was unable to have an MRI scheduled through the company dispensary, he referred her to (Healthcare Provider) where she saw SS. Ms. SS ordered the MRI and, upon reviewing the results, referred Claimant to Dr. J, MD. Dr. J had previously been Claimant's surgeon for a right knee ACL reconstruction using a graft in 2002. Dr. J's 2002 surgery followed a prior ACL reconstruction in the early 80s and a later arthroscopic surgery to repair a bucket-handle tear of the medial meniscus.

Claimant testified that when she went to Dr. J, the only treatment option suggested was a total knee arthroplasty. Dr. J requested pre-authorization for the total knee arthroplasty and Carrier denied the request. After Carrier's second denial of pre-authorization, Claimant requested that the matter be submitted to an Independent Review Organization (IRO). The Department appointed (Independent Review Organization) as the IRO. The IRO assigned the case to a board certified orthopedic surgeon for review. The physician reviewer agreed with Carrier's Utilization Review doctors that the Official Disability Guidelines (ODG) did not support a total knee replacement under the circumstances and that it was not reasonably required health care for the compensable injury. The physician reviewer noted that he had reviewed a letter from Dr. J, dated July 13, 2010, in considering the pre-authorization request.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured

employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines in making decisions about the care of individual patients. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308 (t), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are (sic) considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

With regard to a total knee arthroplasty, also referred to as a total knee joint replacement, the ODG says:

Knee joint replacement

Recommended as indicated below. Total hip and total knee arthroplasties are well accepted as reliable and suitable surgical procedures to return patients to function. The most common diagnosis is osteoarthritis. Overall, total knee arthroplasties were found to be quite effective in terms of improvement in health-related quality-of-life dimensions, with the occasional exception of the social dimension. Age was not found to be an obstacle to effective surgery, and men seemed to benefit more from the intervention than did women. ([Ethgen, 2004](#)) Total knee arthroplasty was found to be associated with substantial functional improvement. ([Kane, 2005](#)) Navigated knee replacement provides few advantages over conventional surgery on the basis of radiographic end points. ([Bathis, 2006](#)) ([Bauwens, 2007](#)) The majority of patients who undergo total joint replacement are able to maintain a moderate level of physical activity, and some maintain very high activity levels. ([Bauman, 2007](#)) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term physical therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. ([Lowe, 2007](#)) The

safety of simultaneous bilateral total knee replacement remains controversial. Compared with staged bilateral or unilateral total knee replacement, simultaneous bilateral total knee replacement carries a higher risk of serious cardiac complications, pulmonary complications, and mortality. (Restrepo, 2007) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008) In this RCT, perioperative celecoxib (Celebrex) significantly improved postoperative resting pain scores at 48 and 72 hrs, opioid consumption, and active ROM in the first three days after total knee arthroplasty, without increasing the risks of bleeding. The study group received a single 400 mg dose of celecoxib, one hour before surgery, and 200 mg of celecoxib every 12 hours for five days. (Huang, 2008) Total knee arthroplasty (TKA) not only improves knee mobility in older patients with severe osteoarthritis of the knee, it actually improves the overall level of physical functioning. Levels of physical impairment were assessed with three tools: the Nagi Disability Scale, the Instrumental Activities of Daily Living Scale (IADL) and the Activities of Daily Living (ADL) Scale. Tasks on the Nagi Disability Scale involve the highest level of physical functioning, the IADL an intermediate level, and the ADL Scale involves the most basic levels. Statistically significant average treatment effects for TKA were observed for one or more tasks for each measure of physical functioning. The improvements after TKA were "sizeable" on all three scales, while the no-treatment group showed declining levels of physical functioning. (George, 2008) This study showed that total knee replacement is second the (sic) most successful orthopaedic procedure for relieving chronic pain, after total hip. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. Hip replacement reduced pain to levels normal for age, reduced physical functioning to within 75% normal levels, and restored quality of life to virtually normal levels. Total knee replacement was the next most successful procedure, and it all but eliminated pain, improved physical functioning to 60% normal, and restored quality of life to within 65% of normal. (Hansson, 2008) A 6-week program of progressive strength training targeting the quadriceps femoris muscle group substantially improves strength and function following total knee arthroplasty for treatment of osteoarthritis, compared to patients who received standard of care therapy; however, addition of neuromuscular electrical stimulation (NMES) to the strength training exercise did not improve outcomes. (Petterson, 2009) Knee replacement surgery is expensive but worth the cost, especially if performed by experienced surgeons, according to a recent study. Some \$11 billion is spent on 500,000 total knee replacements each year in the United States, and the number is projected to multiply seven times by 2030 because of the aging, overweight population. Over 90% knee replacements are successful, knee pain goes away and patients become more mobile. In the study, knee replacement surgery and subsequent costs added up to \$57,900 per patient, which was \$20,800 more than was spent on those who did not get the surgery. Those who got artificial knees lived more than a year longer in good health than those who did not, and the researchers calculated the added cost per year of good-quality life at \$18,300. (Losina, 2009) In a 7-year prospective study, patients with severe osteoarthritis

who had total knee replacement had significant improvements in health-related quality of life, but health outcomes were negatively influenced by obesity and postdischarge complications, and women typically did not get as much benefit from surgery as do men. Overall, 76.8% were satisfied or very satisfied with their total knee replacement, and 79.5% said they would have the surgery again in similar circumstances. (Núñez, 2009) More than 95% of patients report that they are satisfied with the outcome of their total knee replacement 1 year after surgery. Factors that increased risk for dissatisfaction were younger age, being female, valgus alignment of the knee, and posttraumatic arthritis. (Ayers, 2010)

Unicompartmental knee replacement: Recommended as an option. Unicompartmental knee replacement is effective among patients with knee OA restricted to a single compartment. (Zhang, 2008) In this RCT, the early results demonstrated that the unicompartmental knee replacement (UKR) group had less complications and more rapid rehabilitation than the total knee replacement (TKR) group. At five years there were an equal number of failures in the two groups but the UKR group had more excellent results and a greater range of movement. The 15 years survivorship rate based on revision or failure for any reason was 89.8% for UKR and 78.7% for TKR. The better early results with UKR are maintained at 15 years with no greater failure rate. (Newman, 2009) Long-term studies are needed to appropriately define the role of less invasive unicompartmental surgical approaches. (Borus, 2008) Unicondylar knee arthroplasty (UKA) and total knee arthroplasty (TKA) are both recommended for the treatment of medial compartment osteoarthritis in the varus knee. Citing the arduous rehabilitation and bone loss associated with traditional knee arthroplasty, some opt for UKA, especially in young, high-demand patients. (McAllister, 2008) With appropriate patient selection, UKAs are a successful option for patients with osteoarthritis. (Dalury, 2009)

Obesity: After total knee arthroplasty (TKA) for osteoarthritis of the knee, obese patients fare nearly as well as their normal-weight peers. A British research team reports that higher BMI (up to 35) should not be a contraindication to TKA, provided that the patient is sufficiently fit to undergo the short-term rigors of surgery. TKA also halts the decline and maintains physical function in even the oldest age groups (> 75 years). (Cushnaghan, 2008) In this study, the rate of failure of total knee implants, at least up to 5 years after surgery, and the time to failure, were not influenced by patients' BMI, except for subjects affected by morbid obesity, but this group had a small sample size. Based on this evidence, however, it does not appear justified to give low priority to obese subjects for total knee arthroplasty, which would, as a result of restored ability to move, lead to weight loss. (Bordini, 2009) Obese patients presented for and underwent joint replacement surgery at a younger age as compared to nonobese patients. (Gandhi, 2010) Adverse events (eg, perioperative complications, post-op wound infections) occurred in 14.2% of the non-obese, 22.6% of the obese and 35.1% of the morbidly obese patients after total knee replacement. (Dowsey, 2010) A 2-year review of knee and hip replacement surgeries found that complication rates in obese patients were low, supporting doing the procedures even in the heaviest patients, but the review did show that hospital stays were longer in those who were obese than in those who were not. (Parks, 2010) Obese patients may have clinically significant weight loss after total joint arthroplasty, since their osteoarthritis had limited their mobility and ability to exercise. When weight was

corrected for natural gain, the overall study population had a trend toward weight loss, and 19.9% of the study population had clinically significant weight loss. (Stets, 2010)

Minimally invasive total knee arthroplasty: No significant benefit was seen in using a minimally invasive surgical technique over a standard traditional technique for total knee arthroplasty, but the study did not focus on quality-of-life outcomes (eg, length of hospital stay, reliance on pain medications, and the need for inpatient rehabilitation after discharge), in which the minimally invasive approach is purported to show an advantage. (Wüller, 2010)

ODG Indications for Surgery™ -- Knee arthroplasty:

Criteria for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement may be considered. If 2 of the 3 compartments are affected, a total joint replacement is indicated.):

1. Conservative Care: Medications. AND (Visco supplementation injections OR Steroid injection). PLUS

2. Subjective Clinical Findings: Limited range of motion. AND Nighttime joint pain. AND No pain relief with conservative care. PLUS

3. Objective Clinical Findings: Over 50 years of age AND Body Mass Index of less than 35, where increased BMI poses elevated risks for post-op complications. PLUS

4. Imaging Clinical Findings: Osteoarthritis on: Standing x-ray. OR Arthroscopy.

(Washington, 2003) (Sheng, 2004) (Saleh, 2002) (Callahan, 1995)

Claimant testified that Dr. J did not suggest viscosupplementation, steroid injections, or any other conservative care. He feels the only viable option for her treatment is the total right knee arthroplasty. In a letter dated September 23, 2010, Dr. J wrote that “the only way to cure” Claimant’s right knee problems is with the recommended total knee arthroplasty and that steroid injections and viscosupplementation “really do not correct the underlying problem” and would afford only short term relief. At the time of the IRO review, Claimant was less than 50 years old. There is no documentation of nighttime joint pain in Claimant’s medical records, although she testified during the hearing that she experiences nighttime pain. Since Dr. J has not attempted any conservative care, the preponderance of the evidence is not contrary to the IRO decision that evidence based medicine does not support the requested total knee arthroplasty.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

- A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers’ Compensation.
- B. On _____, Claimant sustained a compensable injury while employed by (Employer).

- C. The Texas Department of Insurance appointed (Independent Review Organization) as the Independent Review Organization in this matter.
- 2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.
- 3. Claimant has not received viscosupplementation or steroid injections to the right knee as part of a course of conservative treatment for the compensable injury to the right knee.
- 4. A right total knee arthroplasty is not reasonably required medical treatment for the compensable injury of _____.

CONCLUSIONS OF LAW

- 1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.
- 2. Venue is proper in the (City) Field Office.
- 3. The preponderance of the evidence is not contrary to the decision of IRO that a total right knee arthroplasty is not reasonably required medical care for the compensable injury of _____.

DECISION

Claimant is not entitled to a total right knee arthroplasty for the compensable injury of _____.

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **ACE AMERICAN INSURANCE COMPANY** and the name and address of its registered agent for service of process is

**CT CORPORATION SYSTEM
350 NORTH ST. PAUL STREET
DALLAS, TX 75201**

Signed this 18th day of October, 2010.

KENNETH A. HUCHTON
Hearing Officer