MEDICAL CONTESTED CASE HEARING NO. 09185
M6-09-16728-01

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 June 4, 2009 to decide the following disputed issue:

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

PARTIES PRESENT

Claimant appeared and was represented by LE, an attorney. Petitioner/Provider KB, M.D. appeared as a witness in this matter. Respondent/Carrier appeared and was represented by GW, an attorney.

BACKGROUND INFORMATION

The evidence presented in the hearing revealed that the claimant sustained a compensable injury to her right knee on _____ and was initially diagnosed with contusion and post-traumatic arthritis of the right knee. The evidence further revealed that, since the injury, the claimant has received conservative treatment, such as medication and physical therapy, steroid injection, as well as surgical intervention. On November 6, 2006, ER, M.D. performed arthroscopic surgery in the form of resection of symptomatic medial shelf plica, chondroplasty of the patella, trochlea, medial femoral condyle, medial tibial plateau and lateral tibial plateau on the claimant's right knee. The evidence reflects that the claimant continued to have pain in her right knee after this procedure and on October 16, 2007 underwent a second surgery including arthroscopic examination with medial meniscal tear debridement, abrasion chondroplasty patella and medial femoral condyle and arthroscopic lateral retinacular release by KB, M.D., an orthopedic surgeon.

Further review of the evidence indicates that after the surgical procedures noted above, the claimant received extensive physical therapy, was treated with oral anti-inflammatories, underwent a series of Suparz injections and one corticosteroid injection. Dr. B's records reflect that despite such treatment the claimant's symptoms remained severe, including limitations in her daily activities, decreased range of motion, ability to walk and that she experiences significant night pain inhibiting her sleep. Based on this failure of non-operative treatment, Dr. B recommended a right knee arthroplasty.

In evidence is a response to Dr. B's requested pre-authorization for the proposed procedure by Corvel, dated October 3, 2008. The report indicates that it was provided in response to Dr. B's request for reconsideration and was denied by a physician although no doctor was listed nor was there any indication as to the identity of the author. The report indicates that the rationale behind

the denial of the procedure was that the claimant did not meet all of the indications for surgery found in the Official Disability Guidelines (ODG), specifically that the claimant was 44 years of age and too young for the procedure. The reviewer was also critical that the patient's home exercise program was not adequately discussed nor was she evaluated by a total joint sub-specialist to fully address the risks, benefits and alternatives for the right knee. No other utilization review was included in evidence by any party.

Following Corvel's denial, a request for review by an IRO was made. The IRO reviewer, an orthopedic surgeon, upheld the denial of the right knee arthroplasty.

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. Section 401.011(22-a) defines health care reasonably required 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: (A) evidence based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community." "Evidence based medicine" is further defined, by Section 401.011(18-a) as 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 Division of Workers' Compensation has adopted treatment guidelines under Division Rule 137.100. That rule requires that health care providers provide treatment in accordance with the current edition of the ODG, and treatment provided pursuant to those guidelines is presumed to be health care reasonably required as mandated by the above-referenced sections of the Texas Labor Code. The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the ODG.

With regard to the knee arthroplasty procedure, the ODG provides,

> "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) Unicompartmental knee replacement is effective among patients with knee OA restricted to a single compartment. (Zhang, 2008) 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) 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 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 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) 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) 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)

ODG Indications for Surgery™ -- Knee arthroplasty:

Criteria for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement is indicated. 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. PLUS

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

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

The IRO noted that the claimant was not over 50 years of age and that the diagnosis of end stage osteoarthritis was not supported by the interpretation of the x-rays.

Dr. B testified that the ODG does not rely on evidence based medicine regarding the age recommendation for the procedure. He notes that he reviewed that articles cited in the ODG and that the medical research referenced suggests that regardless of age or body mass index, all patients seem to improve with a total knee arthroplasty. And that although the ODG cites Washington, 2003, Dr. B notes that this is not a study but a list of criteria used by the state of Washington that does not rely upon or reference evidence based medicine. Dr. B further testified that the Claimant met the other criteria under the ODG including conservative care, subjective clinical findings, BMI and osteoarthritis based on arthroscopy.

Based on a careful review of the evidence presented in the hearing, the provider and the claimant failed to meet their burden of overcoming the IRO decision by a preponderance of the evidence-based medicine. The IRO decision in this case is based on the ODG and the evidence revealed that the claimant failed to meet all of the necessary criteria for surgery prescribed in the ODG. The preponderance of the evidence-based medicine is not contrary to the decision of the IRO and, consequently, the claimant is not entitled to the proposed right 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 _____, the claimant was the employee of (Employer) and sustained a compensable injury on that date.

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. Right knee arthroplasty is not health care reasonably required 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 the IRO that right knee arthroplasty is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is not entitled 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 **CENTRAL MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CENTRAL MUTUAL INSURANCE COMPANY
c/o CHARLES W. WASSBERG
7301 NORTH STATE HIGHWAY 161, SUITE 320
IRVING, TEXAS 75039-2820

Signed this 11th day of June, 2009.

Katherine D'Aunno-Buchanan
Hearing Officer