MEDICAL CONTESTED CASE HEARING NO. 09208
M6-09-19331-01

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.

ISSUE

A benefit contested case hearing was held on June 30, 2009, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to total right knee arthroplasty for the compensable injury of _____?

The record was held open, at the request of the parties, until July 9, 2009, to allow the parties to tender additional evidence and responses.

PARTIES PRESENT

Claimant appeared and was assisted by SB, ombudsman. Carrier appeared and was represented by attorney, SB 2.

BACKGROUND INFORMATION

It is undisputed that Claimant sustained a compensable injury on _____, while working in sales and delivery. On that date, he tripped over a cable in a dark storage unit and fell on his knees. The emergency room records show that Claimant was initially diagnosed with a contusion and degenerative joint disease of his right knee. Claimant's treating orthopedic surgeon is Dr. C. His records show he performed arthroscopic partial meniscectomy and abrasion chondroplasty of the right knee for a meniscal tear in 2003; that he may have retorn the meniscus as the result of the fall at work; but, Claimant had significant arthritis in the knee, which further arthroscopic treatment would not improve. In February of 2009, Dr. C requested preauthorization for total right knee arthroplasty.

The carrier's first utilization reviewer cited the *ODG* and denied the requested surgery stating that Claimant needed weight reduction to meet the *ODG* criteria.

The utilization review doctor who reviewed the request on reconsideration also denied the requested surgery. He also cited the *ODG* and stated that Claimant's BMI was 42 and the *ODG* does not recommend any total knee above BMI of 35.

An IRO reviewer, an orthopedic surgeon, reviewed the records on April 16, 2009, and upheld the adverse determinations of the utilization review doctors. The IRO reviewer cited the *ODG* and opined that it was unlikely that the fall caused the osteoarthritis, rather it worsened the pre-existing condition. The reviewer stated that Claimant was reported to be obese with a BMI of 42, and

concluded that Claimant did not meet the *ODG* criteria.

DISCUSSION

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 *Official Disability Guidelines (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**.

ODG

The initial inquiry, therefore, in any dispute regarding medical necessity, is whether the proposed care is consistent with the *ODG*. As the utilization review and IRO doctors in the instant case have stated, the *ODG* allows for arthroplasty and sets out the circumstances under which such treatment is recommended as reasonable and necessary.

The *ODG* Treatment Guidelines for arthroplasty for treatment of the knee refer the reader to "knee joint replacement," which the *ODG* discuss as follows:

> 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)

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)

As noted previously herein, “health care reasonably required” means 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 that evidence is not available, generally accepted standards of medical practice recognized in the medical community. Treatment provided pursuant to the *ODG* is presumed to be health care reasonably required.

Both of the doctors who reviewed the requested arthroplasty and the IRO doctor denied the requested surgery citing the relevant provisions of the *ODG*, specifically the third criteria regarding body mass index.

Claimant cited the *ODG* and *Cushnaghan* study referenced in the *ODG* in support of his position that there is no justification for withholding total knee arthroplasty from obese patients solely on the grounds of their body mass index. Claimant also cited a study entitled *Long-term Outcome of Total Knee Replacement: Does Obesity Matter?* published in the Obesity Surgery Journal (Volume 16, Number 1) in January 2006, which concluded that moderate obesity does not affect the clinical and radiologic outcome of total knee arthroplasty; however, total knee arthroplasty results in improved mobility, enhancing the success of subsequent weight loss therapy.

Dr. C, Claimant's board certified orthopedic surgeon, testified that the BMI of 35 is an artificial threshold and there is no rationale for that threshold cited in the *ODG*. Dr. C testified that Claimant's BMI in May was 8.5 and had reduced to 37.6 at the time of the hearing. He testified that the 35 BMI referenced by the *ODG* ignores an entire body of evidence-based medicine literature holding that there is no justification for refusing to perform total knee arthroplasty from obese patients. Dr. C cited an article published in Orthopedics Today at AAOS (American Academy of Orthopedic Surgeons) entitled *Body Mass Index Found To Not Be A Factor In Knee Arthroplasty Postoperative Pain* as further support of his position.

In the instant case, both parties relied on the *ODG* in support of their position for or against the requested treatment. The IRO cited the *ODG* as well, and opined essentially that because Claimant's BMI exceeds 35 the procedure could not be approved.

When both parties cite the *ODG* in support of their position, that position must be supported by sufficient evidence to justify application of the *ODG*. Mere citation to the *ODG* does not carry the day. In the instant case, the IRO relied solely on Claimant's BMI exceeding 35.

There is evidence-based medicine in support of the proposition that BMI alone should not justify withholding total knee arthroplasty from obese patients. The *ODG* cites two of the peer-reviewed studies cited by the Claimant herein, which lend credence to Dr. C's opinion that the 35 BMI cutoff is arbitrary. In the instant case, Claimant has provided evidence-based medicine sufficient to overcome the IRO opinion. Claimant's BMI exceeds the *ODG* recommended BMI by less than 3 points. Claimant provided an opinion from his board certified orthopedic surgeon, who based his opinion on both the *ODG* and evidence-based medicine studies, as well as his own extensive experience in performing this surgery on patients with a BMI in excess of 35, to explain how Claimant's specific situation justifies a departure from the four criteria set out in the *ODG*.

Under the Act, treatment provided pursuant to the *ODG* is presumed to be health care reasonably required as mandated by the above-referenced sections of the **Texas Labor Code**. In the instant case, Claimant presented an evidence-based medical opinion from a competent source to overcome the IRO's decision. The preponderance of the evidence is contrary to the IRO decision and the Claimant is entitled to the requested total 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 _____, Claimant was the employee of (Employer), when he sustained a compensable injury.

   C. The IRO determined that the requested services were not reasonable and necessary health care services for the compensable injury of _____.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and name and street address of Carrier's registered agent which was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Claimant's orthopedic surgeon recommended total right knee arthroplasty for treatment of Claimant's compensable right knee injury.

4. For treatment of the knee, the *ODG* sets out the circumstances under which total knee arthroplasty is recommended.

5. Claimant meets three of the four ODG criteria for total knee arthroscopy; but, does not meet the third criteria regarding age and body mass and index.

6. The IRO decision upheld the Carrier's denial of the requested total knee arthroplasty for treatment of the left knee injury because the requested surgery did not meet the criteria set out in the *ODG*.

7. Claimant provided evidence-based medicine justifying a departure from the four criteria set out in the *ODG* in his case.

8. The requested total right knee arthroplasty is 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 was proper in the (City) Field Office.

3. The preponderance of the evidence is contrary to the decision of IRO that total right knee arthroplasty is not health care reasonably required for the compensable injury of _____.

DECISION

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

ORDER

Carrier is ordered to pay benefits in accordance with this decision, the Texas Workers' Compensation Act and the Commissioner's Rules.

The true corporate name of the insurance carrier is **SENTRY INSURANCE, A MUTUAL COMPANY** and the name and address of its registered agent for service of process is

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

Signed this 6th day of August, 2009.

Erika Copeland
Hearing Officer