



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 12/26/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Autologous chondrocyte implantation of the knee

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified in 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 or not medical necessity exists for each of the health care services in dispute.

Autologous chondrocyte implantation of the knee – Not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with, P.A.-C. dated 10/03/06, 10/05/06, 10/12/06, 10/19/06, and 10/26/06

DWC-73 forms from Ms. dated 10/03/06, 10/05/06, 10/12/06, 10/19/06, and 10/26/06

X-rays of the right knee interpreted by, M.D. dated 10/03/06

An MRI of the knee interpreted by, M.D. dated 10/21/06

A Workers' Compensation Information Sheet and Physician's Orders dated 10/27/06

Evaluations with, M.D. dated 11/03/06, 11/28/06, 01/17/07, 02/09/07, 03/08/07, 03/09/07, 04/06/07, 05/18/07, 06/29/07, 07/27/07, 10/23/07, 10/24/07, 11/14/07, and 11/16/07

DWC-73 forms from Dr. dated 11/03/06, 03/09/07, 04/06/07, and 06/29/07

Work release forms from Dr. dated 11/13/06, 01/17/07, 02/09/07, 03/09/07, and 07/27/07

A physical therapy prescription from Dr. dated 11/28/06

Physical therapy with an unknown therapist (signature was illegible) dated 12/15/06, 12/18/06, 12/20/06, 01/10/07, and 01/12/07

An operative report from Dr. dated 02/01/07

Physical therapy progress reports from the unknown therapist dated 02/08/07 and 05/07/07

A Required Medical Evaluation (RME) with M.D. dated 07/19/07

A Designated Doctor Evaluation with, D.O. dated 09/19/07

A DWC-73 form from Dr. dated 09/19/07

A Residual Functional Capacity (RFC) report from an unknown provider (no name or signature was available) dated 10/01/07

A letter of authorization, according to an unknown source, from Utilization Review Nurse at dated 10/12/07

A preauthorization request form from Dr. dated 10/24/07

Letters of denial, according to the ODG Guidelines, from Utilization Review Nurse at, dated 10/30/07, 11/29/07

A letter of non-certification, according to the ODG Guidelines, from M.D. at dated 10/30/07

Laboratory studies dated 11/28/07

A letter of non-certification, according to the ODG Guidelines, from M.D. at dated 11/29/07

An undated Summary of Physical Job Demands form

A surgical checklist dated 12/06/07

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 10/03/06, Ms. recommended Naprosyn and Ultracet. X-rays of the right knee interpreted by Dr. on 10/03/06 revealed advanced degenerative changes. An MRI of the right knee interpreted by Dr. on 10/21/06 revealed synovitis, medial plica syndrome, mild chondromalacia, and mild medial compartment osteoarthritis. On 11/03/06, Dr. performed a Cortisone injection and recommended physical therapy and light work duty. Physical therapy was performed with the unknown therapist from 12/15/06 through 01/12/07 for a total

of five sessions. On 01/17/07, Dr. recommended right knee surgery. Right knee surgery was performed by Dr. on 02/01/07. On 02/09/07 and 04/06/07, Dr. recommended further physical therapy. On 06/29/07 and 10/23/07, Dr. recommended another knee surgery. On 07/19/07, Dr. felt treatment was for a preexisting condition and recommended no further treatment for the injury. On 09/19/07, Dr. felt the patient was not at Maximum Medical Improvement (MMI). On 10/30/07, Dr. wrote a letter of non-authorization for a right knee arthroscopy. On 11/29/07, Dr. also wrote a letter of non-authorization for right knee surgery.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

There was some publication regarding this procedure; however, to this date, I think this procedure needs to be considered experimental as the studies have not really born out a true long-term track record with this procedure. I think at best, the literature shows this is as good as microfracture and there are a couple of studies showing they might not be as good. Thus, at this time, I would not recommend this procedure as this falls outside of the ODG and ACOEM, and is not supported by good peer reviewed evidence as a procedure that applies long-lasting relief and changes the natural history of this problem. In addition, Dr. stated that one of the main reasons for going back in is to actually look at the previously done microfracture and possibly do a repeat chondroplasty again. I would consider these ill advised as they would most likely provide no improved release over the previous surgery. Thus, I would not recommend surgery for this. I do not believe the autologous chondrocyte implantation of the knee is reasonable or necessary. This is supported by the ODG and ACOEM.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE**
- 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**

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

X 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)