

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: JULY 24, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthrotomy w/Autologous Chondrocyte Implantation (CARTICEL) Reference #844154
27412, J7330

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity exists for Arthrotomy w/Autologous
Chondrocyte Implantation (CARTICEL) Reference #844154 27412, J7330.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 6/4/08, 6/26/08
ODG Guidelines and Treatment Guidelines
Medical Center, 5/15/08, 2/4/08, 2/12/08, 2/13/08, 4/3/08, 4/7/08, 12/12/07, 1/3/08, 1/4/08,
11/16/07, 11/28/07, 11/8/07, 11/16/07, 11/28/07, 9/20/07, 9/21/07, 9/24/07, 10/19/07, 10/25/07,
11/1/07, 10/1/07, 10/8/07
Left Knee Arthrogram, 10/2/07
MR Knee, 10/2/07
Patient History Questionnaire, 9/19/07
, 5/20/08
, 5/9/08

Operative Note, 5/6/08
Operative Report, 12/20/07
Cartilage Biopsy, 5/7/08
Letter from Dr , MD, 6/23/08
Obesity Articles, March 2002
Current Concepts Review, 2007
Article, December 2003

PATIENT CLINICAL HISTORY [SUMMARY]:

This young male claimant has undergone previous arthroscopic procedures. He is xx years old, having sustained an injury to his knee on xx/xx/xx. He underwent arthroscopic surgery with drilling of the chondral lesion. Apparently, based on the medical records, the chondral lesion between point 96 cm² and 1.5 cm, there was an isolated defect on the medial femoral condyle in the weightbearing zone, not related to any degeneration. Request is for autologous cartilage implantation.

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

The previous reviewers from a purely technical standpoint are correct regarding the patient's body mass index exceeding recommendations, in particular. In addition, this procedure, while showing good initial results, does not have long-standing data or multiple trials to support it. However, given the fact that the procedure does, in fact, follow the line of procedures that are currently recommended, i.e., autologous OATS or mosaic plastic procedures, and given the fact that the cartilage has already been cultured in conjunction with the fact that this man is at an extremely young age, and the consequences of leaving this chondral defect as is may be one or more total joint arthroplasties in the future, this reviewer feels that ODG Guidelines have been met, if not in their last detail, at least in their spirit, and the consequences of not performing the procedure for this gentleman outweighs the current state of knowledge concerning this particular procedure. It is for this reason the previous adverse determination has been overturned. The reviewer finds that medical necessity exists for Arthrotomy w/Autologous Chondrocyte Implantation (CARTICEL) Reference #844154 27412, J7330.

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 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)**