



MedHealth Review, Inc.

445 E. FM 1382
Suite 3344
Cedar Hill, TX 75104
Ph 972-775-1411
Fax 972-775-8035

DATE OF REVIEW: 5/4/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under review include knee arthroscopy and autologous chondrocyte implantation (ACI) and CPT codes 29874 and 52112.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery and has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination in all its parts as it relates to this request.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr. and Carrier.

These records consist of the following: Dr. 4/16/09 attending phys. statement request, med records release of 10/15/08, 11/21/08 to 3/2/09 follow up visit notes, 11/26/08 operative report, 10/9/08 right knee MRI report, 10/13/08 progress note, 9/29/08 progress note-initial visit report and 9/22/08 progress note-initial visit report.

Carrier: LHL009, handwritten note of 2/9/09, 3/12/09 appeal letter for ACI, 2/20/09 denial letter, 4/15/09 letter from patient and 3/16/09 denial letter.

We did not receive a copy of the WC Network Treatment Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a female injured her right knee in fall down stairs at work in xx-xxxx. She underwent arthroscopy for torn medial meniscus in November of 2008 when patellar full thickness defect and loose cartilage fragment was found. Therefore a microfracture procedure was performed. Patient continues with knee pain and further Articular cartilage implant – Carticel surgery as recommended by her treating doctor.

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

As per the ODG, ODG Indications for Surgery™ -- Autologous cartilage implantation (ACI): *Not recommended until further studies are completed, but if used anyway*, Criteria for autologous chondrocyte implantation (ACI):

1. Conservative Care: Physical therapy for a minimum of 2 months. PLUS
2. Subjective Clinical Findings: Injured worker (IW) is capable and willing to follow the rehabilitation protocol. PLUS
3. Objective Clinical Findings: Failure of traditional surgical interventions (i.e., microfracture, drilling, abrasion, osteochondral graft). Debridement alone does not constitute a traditional surgical intervention for ACI. AND Single, clinically significant, lesion that measures between 1 to 10 sq cm in area that affects a weight-bearing surface of the medial femoral condyle or the lateral femoral condyle. AND Full-thickness lesion [*Modified Outerbridge Grade III-IV] that involves only cartilage. AND Knee is stable with intact, fully functional menisci and ligaments. AND Normal knee alignment. AND Normal joint space. AND Patient is less than 60 years old. AND Body Mass Index of less than 35. [* Modified Outerbridge Classification: I. Articular cartilage softening , II. Chondral fissures or fibrillation <1.25 cm in diameter, III. Chondral fibrillation >1.25 cm in diameter ("crabmeat changes"), IV. Exposed subchondral bone.] PLUS
4. Imaging Clinical Findings: Chondral defect on the weight-bearing surface of the medial or lateral femoral condyle on: MRI. OR Arthroscopy.

The ODG further opines ACI is definitely not recommended in the following circumstances: Lesion that involves any portion of the patellofemoral articular cartilage, bone, or is due to osteochondritis dissecans; A "kissing lesion" or Modified Outerbridge Grade II, III, or IV exists on the opposite tibial surface; Mild to severe localized or diffuse arthritic condition that appears on standing x-ray as joint space narrowing, osteophytes, or changes in the underlying bone; Unhealthy cartilage border; the synovial membrane in the joint may be used as a substitute border for up to 1/4 of the total circumference; Prior total

meniscectomy of either compartment in the affected knee (Must have at least 1/3 of the posterior meniscal rim.); History of anaphylaxis to gentamycin or sensitivity to materials of bovine origin; Chondrocalcinosis is diagnosed during the cell culture process.

Because the patient meets some of the non-recommendation circumstances, this procedure is found to be not medically necessary at this time. This is due to the contra-indications listed by the ODG for the requested procedure.

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)**