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Notice of Independent Review Decision

DATE OF REVIEW: August 23, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee arthroscopy

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

Fellow American Academy of Orthopaedic Surgeons

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (06/30/10, 07/13/10)

Dr.

- Office visits (08/31/09 - 06/24/10)
- Surgery (09/17/09)

Associates:

- Diagnostic tests (08/14/09)
- Office visits (08/31/09 - 06/24/10)
- Surgery (09/17/09)

Attorney at Law:

- Office visits (07/11/09 - 06/24/10)
- Diagnostic tests (07/11/09 – 09/10/09)
- Therapy (07/14/09 – 04/05/10)
- Surgery (09/17/09 - 05/19/10)
- Utilization reviews (06/30/10, 07/13/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xxx who was on a on xx/xx/xx. He landed on his left leg which then caused the knee to pivot and twist. He states, he felt a pop in his left knee and it became swollen. He sustained injuries to his back and neck as well.

2009: Following the injury, the patient was evaluated at Medical Center emergency department (ED) for back and left knee pain. History was significant for anterior cruciate ligament (ACL) reconstruction on the left 10 years ago. X-rays of the cervical/lumbar spine, pelvis and the right hip revealed no acute injury. X-rays of the left knee revealed advanced degenerative joint disease (DJD) with narrowing of the medial compartment and bulky spurring along the adjacent articular surfaces of the distal femur and tibial plateau, postsurgical changes, small suprapatellar effusion and small 1-2 mm radiopaque density in the anterior aspect of the joint space. The patient was diagnosed with cervical/lumbosacral strain with muscle spasms and left knee strain and was treated with intravenous (IV) and oral pain medications.

The patient was then evaluated at where he was diagnosed with unspecified internal derangement of the left knee and cervical/thoracic/lumbar strain. He was treated with acetaminophen/hydrocodone, Vicodin, Biofreeze, aluminium crutches and physical therapy (PT).

Magnetic resonance imaging (MRI) of the left knee revealed: (1) Postsurgical changes from previous ACL reconstruction. (2) Radial free margin fraying/tearing in the posterior horn of the medial meniscus, greater near the root ligament attachment, radial irregularity and/or tearing at the junction of the posterior horn and body and mild diminution of the body in this region. (3) Mild-to-moderate tricompartmental joint space loss, greater in the medial, followed by patellofemoral compartments; mild tricompartmental osteophytosis; grade II-III chondromalacia, greatest in the medial compartment. (4) Small joint effusion and a small Baker's cyst. (5) Foci of irregular low signal intensity in Hoffa's fat pad probably reflecting chronic scarring and/or fibrosis. Underlying inferior patellar plica was possible. (6) Mild chronic patellar tendon thickening/tendinopathy.

An orthopedic surgeon noted swelling, instability, locking and catching in the left knee. Examination revealed minimal effusion and crepitus of the patellofemoral joint. He obtained MR arthrogram of the left knee that revealed: (1) Finding suspicious for ACL graft tear. There was about 1.5 cm anterior translation of tibia. ACL graft was not identified. (2) Myxoid degeneration and possible subtle inferior surface tear in the medial meniscus posterior horn. Findings were also suspicious for possible inferior surface tear in the lateral meniscus posterior horn. (3) Moderate medial and lateral compartment osteoarthritis. There was grade II to IV chondromalacia in medial compartment. (4) Small amount of fluid in gastrocnemius/semimembranosus bursa. Scarring in infrapatellar fat pad compatible with prior surgery. MRI of the lumbar spine revealed degenerative changes at L1-L2, L4-L5 and L5-S1.

A physical performance evaluation (PPE) placed the patient in the light physical demand level (PDL) as against his job required PDL of heavy. The evaluator referred the patient for active therapy.

M.D., an orthopedic surgeon, noted the patient was unable to straighten or bend the left knee. He also reported instability and multiple episodes of locking about the knee. Examination revealed small intraarticular effusion, tenderness along the medial and lateral joint line and positive anterior drawer's, Lachman's and medial McMurray's. X-rays of the left knee revealed postsurgical changes and some osteophytes along the patella and early degenerative changes about the medial and lateral joint lines. Dr. diagnosed left knee ACL and medial/lateral meniscus tear.

On September 17, 2009, Dr. performed left knee arthroscopy, partial medial and lateral meniscectomy, microfracture of the medial femoral condyle and chondroplasty of the lateral femoral condyle. Intraoperative findings revealed bony overgrowth narrowing the intracondylar notch, but there was no evidence of ACL graft as it was completely torn.

The patient underwent postoperative rehabilitation protocol.

MRI of the cervical spine revealed degenerative changes from C2-C7. M.D., obtained x-rays of the lumbar spine, which were consistent with mild narrowing at L4-L5 and L5-S1. He diagnosed cervical and lumbar soft tissue injuries and continued the patient on conservative treatment.

D.O., a pain management physician, diagnosed chronic back, buttock, and left leg pain syndrome consistent with lumbar disc bulge/protrusion; left lumbar radiculopathy with secondary complex regional pain syndrome (CRPS); status post meniscal repair on the left; myofascial pain syndrome of the cervical/mid thoracic/lumbar region and reactive depression and anxiety in a chronic pain state. He treated the patient with a series of epidural steroid injections (ESIs) in 2009 and 2010 and with medications including Cymbalta, Clonazepam, Neurontin and hydrocodone.

2010: Dr. noted pain, inflammation and articular effusion in the left knee. He discussed it was likely due to the cartilage damage that was within the knee, especially along the medial femoral condyle, which was worn right down to the bone. He treated the patient with Supartz injection x3, Ultram and hydrocodone and provided him with a cane.

In March, M.D., a designated doctor, deferred assessment of maximum medical improvement (MMI), pending a shot in tailbone. He stated the patient could return to work with restrictions and the extent of injury included back, knees and neck.

Dr. noted temporary improvement following the Supartz injections. X-rays of both the knees revealed worsening of the joint space narrowing and osteophytes particularly in the lateral compartment of the left knee. Dr. felt the ACL revision surgery would not be sufficient to alleviate the pain and recommended a total knee replacement (TKR) as the only option, but it was not ideal at patient's age of xx.

From March through April, the patient underwent therapy consisting of hot moist packs, electrical muscle stimulation (EMS) and ultrasound. He was then instructed on home exercises.

M.D., denied the request for a left TKR as there was absence of the ACL at the time of surgery and narrowing of the intercondylar notch with bony overgrowth. This was evidence that the patient did not have an ACL prior to the fall. Also the findings of the MRI indicated significant pre-existing osteoarthritis. He also did not fulfill the age criteria.

In May, M.D., an orthopedic surgeon, issued a letter and opined the revision ACL surgery would not be sufficient to alleviate the patient's pain. Unfortunately, the only option would be a total knee arthroplasty. Although it was not ideal at age of xx; however, there was really no alternative to suffering pain. Dr. therefore disagreed with the denial of total knee arthroplasty and felt that the patient met the majority of the criteria including failure of conservative care including medications and Viscosupplementation injection; and clinical findings of joint pain, limitation of motion, crepitus, nighttime pain; body mass index of about 25. Dr. stated though the patient had pre-existing condition of his knee that was original ACL injury in 1999, did cause some of degeneration of knee; however, there was no indication that the graft failed prior to his fall and there was every indication including patient's symptoms, popping and swelling that he had in the knee that the ACL failed at the time of fall in, and failure of graft caused acceleration of the degeneration of his knee. Dr. therefore submitted an appeal regarding the denial for surgery.

M.D., denied the appeal for a left TKR as he was xx years old and she was concerned that he had 11 years to suffer with knee pain and instability prior to meeting criteria published in the ODG for preauthorization total knee arthroplasty.

On June 24, 2010, Dr. noted the patient continued to have severe left knee pain interfering with the daily activities. His surgery was denied again and the only reason was his age. Dr. felt there was no way the patient was going to make it 10 years before requiring TKR. Examination revealed significant chondromalacia to the knee, diffuse tenderness, decreased range of motion (ROM) and mild ACL instability. Dr. diagnosed posttraumatic arthritis to the left knee and discussed other options, which included left knee arthroscopy for debridement and followed by repeat Synvisc injections. The patient had failed conservative measures including injection, therapy and bracing. His radiographic studies revealed diffuse joint space narrowing and evidence of posttraumatic arthritis. Dr. recommended proceeding with the knee arthroscopy.

On June 30, 2010, M.D., denied the request for left knee arthroscopy based on the following rationale: *"I was not able to speak with Dr.. I called and attempted to speak to Dr. and per, Dr. stated that he had never seen this patient and he did not feel comfortable in doing a peer review and speaking on behalf of Dr.. Based on evidence based ODG guidelines, the request for surgical arthroscopy and chondroplasty cannot be supported from the records that are available for review. Evidence-based literature does not support the role of chondroplasty as the primary treatment for osteoarthritis as it has been well-documented that arthroscopic surgery for knee arthritis adds no significant benefit when compared*

to physical therapy, home exercises and medical treatment. Based on the above, the request for the need for surgical arthroscopy for debridement cannot be supported as medically necessary from the information available for review”.

On July 13, 2010, Dr. denied the appeal for left knee arthroscopy based on the following rationale: “I spoke to Dr.. She is somewhat frustrated that she feels she has nothing else to offer this patient except a debridement type arthroscopy. She offered to fax some additional literature to offset the generally held position that there is limited benefit to be obtained from arthroscopy for osteoarthritis. Patients with mild-to-moderate osteoarthritis appear to have some benefit in the form of symptomatic relief available with a debridement type arthroscopy. However this patient appears to suffer a more severe advanced posttraumatic osteoarthritis. He has been described as a candidate for unicompartmental arthroplasty. It would appear that the prior denial was appropriate and should be upheld. Applicable passages from the ODG, 2010, in knee chapter are cited above. The literature synopses submitted by Dr. are included. The likelihood of obtaining ‘good or excellent’ result is below acceptable. Adverse determination is respectfully recommended”.

Per a physician’s progress note dated July 20, 2010, the patient was scheduled for left knee arthroscopy on July 28, 2010. He was prescribed tramadol, Flexeril, hydrocodone and Cymbalta.

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

The requested service is left knee arthroscopy. Based on review of the documentation, the patient now has post traumatic arthritis due to a pre-existing anterior cruciate ligament injury and subsequent surgery. On xx/xx/xx, the patient already had an arthroscopy with debridement. At the time of that arthroscopy it was noted to have tricompartmental osteoarthritis. An arthroplasty has been requested but denied due to the patient’s age. According to ODG guidelines arthroscopic debridement in patients with this extensive osteoarthritis would be of no benefit, therefore the request is denied.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES