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Notice of Independent Review Decision

DATE OF REVIEW:

August 26, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right total knee replacement with three days inpatient stay

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

Certified, American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

X Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Diagnostics (11/09/05, 09/02/06)
- Office visits (11/16/05 - 07/22/10)
- Operative reports (12/12/05, 09/25/06)
- FCE (03/21/07)
- Reviews (02/01/07)
- Utilization reviews (06/25/10 – 08/03/10)

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- Operative reports (12/12/05, 09/25/06)
- Office visits (09/27/06 - 07/22/10)
- Therapy progress notes (10/09/06 – 03/21/07)
- Reviews (02/01/07)
- Utilization reviews (06/25/10 – 08/03/10)

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- Utilization reviews (06/25/10 – 08/03/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who fell off the top of a pole when he was coming down and his right knee locked on xx/xx/xx.

2005 – 2006: In November 2005, magnetic resonance imaging (MRI) of the right knee revealed chondromalacia and degenerative changes in the medial compartment with tear of the body and posterior horn of the medial meniscus.

M.D., an orthopedic surgeon, saw the patient for persistent pain and popping in the right knee. History was positive for arthroscopy of the knee, diabetes and hypertension. Examination revealed positive medial McMurray, tenderness along the medial joint line and pain at extremes of motion. Dr. diagnosed internal derangement of the right knee and medial meniscus tear.

On December 12, 2005, Dr. performed diagnostic arthroscopy of the right knee with partial medial and lateral meniscectomy. Postoperatively, the patient attended 18 sessions of physical therapy (PT) consisting of therapeutic exercises, modalities and manual techniques aimed at decreasing swelling and improving functional strength and range of motion (ROM). Dr. noted the patient was recovering steadily.

On February 25, 2006, Dr. performed diagnostic arthroscopy of the right knee with arthroscopic partial medial and lateral meniscectomy. Postoperatively, he aspirated 50 cc of fluid and injected Kenalog and Xylocaine. The patient had full ROM and was recommended aggressive rehabilitative exercises and strengthening.

In July 2006, the patient complained of a sudden increase in the right knee pain. Examination showed tenderness across the medial joint line and significant pain with McMurray's maneuver. Dr. obtained MRI of the right knee that revealed attenuation of the medial meniscus possibly representing interval meniscectomy; however, a meniscal tear could not be conclusively excluded. There were degenerative changes and chondromalacia of the medial compartment noted.

On September 25, 2006, Dr. performed comprehensive diagnostic arthroscopy of the right knee with arthroscopic partial medial and lateral meniscectomy. Postoperatively, the patient attended 18 sessions of PT consisting of therapeutic exercises, modalities and manual techniques aimed at improving strength and ROM. He was improving steadily.

M.D., a pain management physician, noted moderate tenderness in the right knee and slight limping. He prescribed Lortab.

From December 2006 through January 2007, the patient attended 20 sessions of work conditioning program (WCP).

2007: In January, Dr. prescribed Q-lock brace. Dr. noted improved strength and ROM; however, the morbid obesity caused some difficulty getting

him back to climb poles. He recommended returning to work on a limited working category.

M.D., and M.D., performed a peer review and noted that Dr. had assigned 1% whole person impairment (WPI) rating. Dr. rendered the following opinions: (1) The extent of injury was right knee medial and lateral meniscal tear status post right knee arthroscopy x2. (2) Current or ongoing treatment, continued orthopedic treatment, prescription medications, durable medical equipment (DME) or diagnostic testing were not reasonable or necessary. (3) The patient was not a surgical candidate.

Dr. performed Kenalog and Xylocaine injection to the knee.

On September 10, 2007, M.D., assessed MMI with 3% whole person impairment (WPI) rating.

In October, Dr. noted occasional shooting pain throughout the knee. However, the patient was overall doing better. Dr. released him to work with modifications and recommended follow-up as needed.

2008: From January through August, the patient was seen by Dr. for episodes of pain in the right knee with physical activity, bending and stooping. Dr. performed Kenalog and Xylocaine injection with significant improvement.

2009: No records are available.

2010: On June 16, 2010, Dr. saw the patient for significant pain with progression of pain over the years. The patient was limping and in constant pain. Examination revealed a lateral thrusting gait. Dr. obtained standing x-rays of the knee that showed a 2-mm space in the medial compartment compared to x-rays taken in 2007 which showed 7 mm. Dr. assessed progressive posttraumatic injury to the right knee with traumatic arthritis and recommended a total knee replacement (TKR).

Per utilization review dated June 25, 2010, the request for right TKR with three days inpatient stay was denied with the following rationale: *“Per June 16, 2010, medical report, the patient was limping and in constant pain. Physical examination to the right leg showed a lateral thrusting gait and BMI of 38. There was no detailed description of the pain pattern such as nighttime joint pain and physical examination findings of the right knee showing limited ROM. Additionally MRI of the right knee done mainly discussed affectations to the medial compartment only implying that only one knee compartment was affected. Also there was no clear finding of osteoarthritis on the patient’s standing x-rays of the right knee. The patient’s BMI also increases the patient’s risks for postoperative complications for the procedure. There was also no adequate evidence of failure of conservative treatment in this patient due to lack of supporting documentation of the treatment rendered. In light of a non-certifiable surgery, the request for three days of inpatient stay is considered not medically necessary. Therefore, the clinical information obtained does not establish the medical necessity, clinical utility and anticipated potential benefits of these effects.”*

On July 22, 2010, Dr. opined the patient had failed two arthroscopies, steroid injections, visco supplementation, PT and suffered from severe pain. He opined the only definitive treatment for the work-related injury and traumatic cartilage loss was a total knee replacement.

Per reconsideration review dated August 3, 2010, the request for TKR with three days inpatient stay was denied with following rationale: *“Based on the clinical documentation provided for review, it appears that the patient has joint space narrowing in the medial compartment only. Per ODG guidelines, degenerative joint disease should be present in two or more compartments in order to consider a total knee arthroplasty. As the patient appears to have joint space narrowing only in the medial compartment with lack of significant osteoarthritis in any of the other compartment of the right knee, a total knee arthroplasty would not be indicated. Additionally, the patient’s BMI is 38 which places the patient at an increased risk for failure of components and knee arthroplasty for patients BMI of over 35 is not recommended by ODG guidelines. As such appropriateness is not established at this time.”*

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

The opinions provided by the physicians performing the preauthorization analysis appear to be accurate and consistent with ODG criteria. There is insufficient objective clinical evidence submitted by the requestor that would obviate the ODG criteria.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES