

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: October 27, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee unicondylar replacement.

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

M.D., 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)

Left knee unicondylar replacement is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 9/30/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/1/10.
3. TDI Notice to IRO of Case Assignment dated 10/5/10.
4. Utilization Review Referral form.
5. Medical records from MD and MD dated 12/1/09, 2/9/10, 2/16/10, 3/2/10, 3/30/10, 4/13/10, 4/19/10, 4/23/10, 5/17/10, 5/24/10, 6/2/10, 6/9/10, and 6/30/10.
6. Medical records from Medical Centers dated 2/18/10, 2/22/10, 2/24/10, 3/1/10, 3/3/10, 3/4/10, 3/8/10, 3/15/10, 3/17/10, 3/22/10, 3/31/10, and 4/20/10.
7. Operative report dated 2/8/10.
8. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

A review of the record indicates the patient sustained an injury on xx/xx/xx. On 2/8/10, she underwent left knee arthroscopic partial lateral meniscectomy and chondroplasty of medial femoral condyle chondral injury. Follow-up on 2/16/10 noted the patient was ambulating on her left lower extremity with a slight antalgic gait and she had full active extension with flexion to approximately 90 degrees. On 4/19/10, the patient's provider noted the patient's pain had worsened, she had trouble walking, and she was using a cane for ambulation. The patient was started on Celebrex. She subsequently received Supartz injections (times 4) without relief. The patient's provider has recommended post-traumatic unicondylar replacement of the left knee.

The Carrier indicates the requested service is not medically necessary. According to the Carrier, there is no evidence of significant osteoarthritis in any compartment of the left knee that would reasonably require the requested surgical intervention.

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

The requested unicondylar replacement is not medically necessary. The patient has a chondral lesion of the medial femoral condyle. The size of the lesion is not clearly documented in the records provided. The operative report indicates a chondroplasty was performed with respect to this lesion. There was no mention of microfracture in the report. An MRI documented chondromalacia only. There is no evidence of joint space narrowing, osteophytes and sclerosis to support the necessity of unicondylar replacement. Given the lack of evidence of clinical indications for unicondylar replacement as well as this patient's young age, I have determined that the requested procedure is not medically necessary.

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)