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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 20, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Right total knee arthroplasty (27447)

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

- Radiodiagnostic studies (01/20/09, 06/17/10)
- Office notes (02/04/09 – 09/08/10)
- Operative notes (04/17/09, 08/07/09)
- Therapy discharge note (12/16/09)

Dr.

Radiodiagnostic studies (01/20/09 – 06/17/10)
- Office notes (02/04/09 – 09/08/10)
- Operative notes (04/17/09, 08/07/09)
- Lower extremity Doppler studies (08/26/09, 08/31/09)

TDI
- Utilization Reviews (09/01/10, 09/24/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his right knee and right ankle on xx/xx/xx , when the boards on a trailer he was stepping on gave way causing him to fall through, catching his leg and twisting.

The patient initially sought treatment with Dr. who obtained magnetic resonance imaging (MRI) of the right knee. The MRI showed osseous contusions involving the proximal medial tibia and the proximal fibula; chronic osteochondral lesion involving the lateral femoral condyle, likely the sequela of remote trauma; avulsion of the meniscofemoral extension of the deep medial collateral ligament (MCL) and chondromalacia of the patellofemoral compartment.

MRI of the right ankle revealed tibiofibular syndesmotic sprain with high-grade sprain or partial tear of the anterior tibiofibular ligaments; minimal fluid in the common peroneal tendon sheath; mild posterior tibial tendinopathy and a small ganglion measuring about 14 x 7 mm.

M.D., an orthopedic surgeon, assessed third degree right ankle sprain and right knee sprain with OCD lesion. He initially treated the patient conservatively with physical therapy (PT) to the right knee and ankle and a Kenalog injection to the right knee. The right ankle condition improved but not the knee.

On April 17, 2009, Dr. performed right knee arthroscopy with major synovectomy, partial medial meniscectomy and chondroplasty of the patella, patellar femoral groove and lateral condyle.

Postoperatively, the patient continued to experience severe pain and swelling in the right knee that did not improve with Kenalog injection or PT. In view of severe patellofemoral degeneration as well as a big OCD lesion on the lateral femoral condyle, Dr. performed a right knee MosaicPlasty with autograft and allograft and synovectomy on August 7, 2009.

Three weeks after the surgery, the patient developed right lower extremity pain with discoloration, temperature changes and swelling. Right lower extremity venous Doppler was essentially unremarkable while arterial Doppler showed occlusion of peroneal artery. In September, Dr. obtained x-rays and noted healing mosaicplasty plugs. He started PT for ROM and strengthening. Toe touch weightbearing was advanced to full weightbearing over the course of three weeks and then crutches were discontinued. The patient attended 19 sessions of rehabilitation to his right knee with improvement.

By November 2009, x-rays showed healed mosaicplasty. In December, Dr. released him to full duty work without restrictions. He noted the patient had no pain but did have excessive weakness and giving way of knee.

The patient went back to work and did well for some time, but later developed increasing pain in his knee without any traumatic cause. In June 2010, MRI of the right knee was obtained that showed: Small joint effusion; abnormal horizontal cleavage signal in the posterior horn of medial meniscus possibly representing post meniscectomy scar or tear; globular signal abnormality in the medial femoral condyle extending through the cortex and globular signal abnormality in the lateral femoral condyle possibly representing a degenerative geode or osteochondral lesion measuring 1.2 x 1 cm with overlying articular cartilage abnormality.

Dr. reviewed the MRI findings and felt that the grafting had been reabsorbed and was no longer effective therefore causing exposed bone at the articular surface of the medial femoral condyle. He assessed failed MosaicPlasty causing severe pain and functional loss and recommended arthrosurface with a small implant on the medial femoral condyle versus a unicondylar replacement.

On August 18, 2010, Dr. noted the patient did not get relief from conservative measures. The patient was unable to sleep at night due to pain. Examination showed pain with axial loading of the extremity, i.e., compressing of the knee joint surfaces, very focal point tenderness with palpation to the distal end of the medial femoral condyle as well as the lateral femoral condyle. There was 1+ effusion, crepitation with ROM and antalgic gait. Dr. stated the patient was walking on bone-on-bone surfaces and again recommended a resurfacing procedure.

On September 1, 2010, the pre-authorization request for right knee arthroplasty was denied with the following rationale: "*The MRI of the right knee dated June 17, 2010, showed medial meniscal tear with postoperative changes, postsurgical changes at the medial femoral condyle, degenerative changes of the lateral femoral condyle and intact ligaments. Based on the submitted clinical notes, the patient underwent conservative treatment such as PT, injections and medications with minimal relief. However, there is no documentation of at least two of three compartments affected and objective findings [over 50 years of age and Body Mass Index (BMI) of less than 35]. The necessity of the requested surgery was not established."*

On September 8, 2010, the patient returned to Dr. for continued pain in his right knee throughout the day with weightbearing as well as nighttime pain that made him very difficult to sleep. Dr. reported the patient had undergone viscosupplementation as well as Kenalog injections but continued to have increased pain in his right knee. Recent MRI showed a significant loss in both the medial and lateral compartments and at this point was best served by a total knee replacement. The patient in spite of surgery and repeat MosaicPlasty had worsened after attempting to work and now walked with an antalgic gait. He had a BMI that calculated to 31.5 based on his height of 6'4" and 258 pounds. The patient had not been able to work due to pain. Therefore, Dr. made an appeal for knee replacement so that the patient could return to the working place after recovering from surgery.

On September 24, 2010, an appeal for right knee arthroplasty was denied with the following rationale: *"As per medical records, the patient sustained injury on xx/xx/xx, and has undergone right knee arthroscopy, mosaicplasty with autograft and allograft and synovectomy. However, the operative report was not included for review to evaluate the intraoperative findings. In the clinical report dated September 8, 2010, the patient complains of right knee pain. He has antalgic gait with BMI of 31.5. The MRI scan mentioned significant cartilage loss in both the medial as well as lateral compartments. However, the official result was not included for review. Based on the guidelines, surgery can be considered if there is failure of conservative management like PT, medication, viscosupplementation injections or steroid injection and activity modification. The clinical records indicated that the patient has been treated conservatively with steroid injections. However, the clinical information did not provide objective documentation of the patient's clinical and functional response from the mentioned injection that includes sustained pain relief, increased performance in the activities of daily living (ADL) and reduction in medication use. Furthermore, there was no evidence provided that this patient had stretching or strengthening exercises or had maximized the effect of oral medications. There was no PT progress notes attached indicating non-improvement. Likewise, the pain medications given were not included for review. The maximum potential of the conservative treatment done was not fully exhausted to indicate a surgical procedure. Hence the necessity of the requested surgical procedure was not established."*

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

THE PATIENT WHO UNDERWENT A KNEE ARTHROSCOPY AND SUBSEQUENT MOSIACPLASTY FOR AN OSTEOCHONDRAL DEFECT IN THE LATERAL FEMORAL CONDYLE. THE PATIENT RETURNED BACK TO DUTY IN DECEMBER 2009 AND IS NOW NOTED WITH PROGRESSIVE ONSET OF PAIN. TWO PHYSICIANS HAVE NOTED THAT THE MOSAICPLASTY HAS ABSORBED AND THE PATIENT HAS A PAINFUL OSTEOCHONDRAL DEFECT IN THE LATERAL FEMORAL CONDYLE. RECENT MRI SCAN SHOWED LOSS OF CARTILAGE IN THE MEDIAL LATERAL COMPARTMENTS. REQUEST HAS BEEN MADE FOR A TOTAL KNEE REPLACEMENT. THERE IS NO DOCUMENTATION THAT THIS PATIENT HAS HAD STERIOD INJECTION AND/OR VISCOSUPPLEMENTATION INJECTION SINCE DECEMBER 2009. THE PATIENT DOES MEET THE CRITERIA FOR BODY MASS INDEX AS WELL AS THE ARTHROSCOPY DEMONSTRATING THE OSTEOCHONDRAL DEFECT AS WELL AS OTHER NON-OPERATIVE CARE. IF THE PROVIDER CAN PROVIDE DOCUMENTATION THAT THE CLAIMANT HAS HAD INJECTION TREATMENT THEN THE PROCEDURE SHOULD BE CERTIFIED. AT THIS TIME, THERE IS NO DOCUMENTATION FROM THIS REVIEW THAT THIS PATIENT HAS HAD LOWER LEVEL OF CARE INCLUDING THE VISCOSUPPLEMENTATION OR STERIOD INJECTIONS AND THEREFORE THE DENIAL.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**