

CareReview™

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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 20, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpt LOS x 3-5 Days Left Knee Total Arthroplasty 27447

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On July 20, 1999 the claimant was seen at Orthopaedics and Sports Medicine, P.A. by PA. The HPI states the claimant is a gentleman who stumbled and fell coming down a ladder at work on xx/xx/xx. He was seen and treated for increased pain in the left knee in the ER. Aspiration was undertaken and an AP and lateral of the knee. He was then referred for further care. The physical examination states there is no erythema/induration, there is an induration to his right knee. There is mild to moderate effusion and the claimant underwent an aspiration of 60cc of a bloody aspirate. It was then injected with .5% marcaine. It grossly appears to be stable. But, his standing AP films were taken showing a very significant amount of arthritis in the right knee. In the left knee there's some mild minimal changes. On the sunrise view it's completely within normal limits, AP and lateral are otherwise unremarkable. The assessment states this is probably secondary to an internal derangement due to his hx of gout. He probably has a meniscal tear with brittle intercartilaginous menisci. Plan states claimant will undergo a MRI, stay on crutches, will be placed in a light compression dressing for a few days. I feel he's going to require an arthroscopy in the near future.

On July 22, 1999 the claimant underwent an MRI of the left knee-extended study interpreted by MD.

The Impression states:

1. Maceration of the ACL
2. Complex tear of the anterior horn of the lateral meniscus with extension into the body.
3. Probable disruption of the inferior meniscocapsular ligament.
4. Possible disruption of the lateral capsule.
5. Cystic collection extending for the posterior horn of the lateral meniscus with heterogeneity which suggests loose bodies or synovial hypertrophy.
6. Contusion of the posterolateral tibial plateau.
7. Large effusion with synovial hypertrophy and/or loose bodies
8. Findings suggestive of partial injury to the fibular collateral ligament.
9. Thickening and abnormal signal within the popliteal tendons which appears intact. This suggests inflammation secondary to injury.
10. Grade III chondromalacia patella.

On August 9, 1999 there is an operative report by DO. Preoperative diagnosis was: Internal Derangement Left Knee. Postoperative diagnosis was: Medial and Lateral Meniscus Tear Left Knee, ACL Tear Left Knee, Multiple Loose Bodies of the Left Knee.

On January 13, 2011 the claimant is seen at Orthopaedics and Sports Medicine, P.A. by PA-C. The history of the present illness states the claimant reported he was just walking around in the kitchen and felt a sharp pain after twisting off that knee. It got progressively worse until he had extreme pain and swelling. The claimant took prednisone which helped it to some degree but really he is still limping around on the. The patient's date for his injury is xx/xx/xx.

Musculoskeletal examination states the claimant had a ligamentously unstable knee with positive anterior drawer and positive McMurray's examination. Imaging states that "we looked at multiple views on Synapse of that knee. The patient does have significant arthritic changes". The plan stated was for an MRI and return to Dr.

On January 26, 2011 an MRI were performed on the Left Knee (ACL injury, medial meniscus tear), radial 3-D gradient reformatted images are included.

Impressions were:

1. Moderate joint effusion, complex, likely synovial proliferative changes, suspect lipoma arborescens.
2. Slightly high-riding patella, mild lateral patellar subluxation.
3. Grade IV chondromalacia, trochlea, grade III chondromalacia elsewhere with substantive chondral thinning, particularly lateral compartment where early grade IV chondromalacia is also present.
4. Grade II injury, MCL, subtle grade I proximal LCL injury, suspect chronic synovial inflammatory changes, see next impression.
5. Prominent fluid adjacent to lateral meniscus/deep to the iliotibial band, subtle grade I injury proximal fibular collateral component of LCL, suspect

- also an element of chronic synovial inflammatory changes deep to the iliotibial band. Please correlate clinically, see discussion above.
6. Horizontal oblique tear, posterior horn and body lateral meniscus with a foreshortened inner one-third white-white zone medial meniscus and minutive posterior horn and horn root junction.
 7. Horizontal oblique tear also present, posterior horn and horn body junction, medial meniscus as well as anterior horn body junction, medial meniscus.
 8. Signal alteration within the medial head, gastronemius which most likely represents lipoma, no frank stranding of the lesion and normal appearance of the adjacent musculature, follow up with T1 imaging and axial stir images with position similar to what we have here would be recommended for sake of completeness.
 9. High grade of ACL injury
 10. Generalized soft tissue edema is noted about the knee.

On March 1, 2011 the claimant attended a follow up visit with DO. The physical examination states on standing films the claimant is relatively bone on bone in the entire lateral aspect of the knee and medial aspect of the knee. He has had dramatic subchondral collapse. The MRI shows dramatic proliferative changes with grade 4 chondromalasia changes. Basically tricompartmental osteoarthritis and collapse. Certainly having an old anterior cruciate ligament tear with this left knee puts him at risk of this and now xx years down the road is certainly to the point where there is just not a lot options left for him as far as other than a total knee arthroplasty. Dr. goes on to state "looking through the MRI, I do not really see any way to go but that. Certainly in looking at standing films gave a significant warning that that was gong to be the case. At this time, with the tricompartmental changes that he has I think that he needs total knee arthroplasty. The problem and the question both are with Work Comp, this originally being a Work Comp covered knee, under the old law, with the anterior cruciate ligament tear that was never reconstructed secondary to the age and osteochondral damage done to the joint at the time, now xx years later he needs a knee replacement Justas we had projected at the time.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male with a history of diabetes mellitus, hypertension, coronary artery disease, chronic kidney disease, kidney stones, bladder infections, hepatitis A, osteoarthritis, gout and surgical history of right knee open mini arthrotomy, complete meniscectomy '71 and cholecystectomy, two-vessel coronary artery bypass surgery, obesity.

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

The previous decisions are upheld. Per the medical records submitted the claimant has a BMI of 49.5 which is well over the recommended 35 and there was no documentation submitted that the claimant has received any injections.

Since the claimant does not meet the ODG Guidelines for knee arthroplasty the previous decisions are upheld.

ODG Indications for Surgery™ -- Knee arthroplasty:

Criteria for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement may be considered. If 2 of the 3 compartments are affected, a total joint replacement is indicated.):

1. Conservative Care: Medications. AND (Visco supplementation injections OR Steroid injection). PLUS

2. Subjective Clinical Findings: Limited range of motion. AND Nighttime joint pain. AND No pain relief with conservative care. PLUS

3. Objective Clinical Findings: Over 50 years of age AND Body Mass Index of less than 35, where increased BMI poses elevated risks for post-op complications. PLUS

4. Imaging Clinical Findings: Osteoarthritis on: Standing x-ray. OR Arthroscopy.

([Washington, 2003](#)) ([Sheng, 2004](#)) ([Saleh, 2002](#)) ([Callahan, 1995](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).

See also [Skilled nursing facility LOS](#) (SNF)

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)