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Notice of Independent Review Decision

Date: June 19, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right total knee replacement

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

Board Certified Orthopaedic Surgeon
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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury when he was xxxxx. He sustained right knee/meniscus tear.

In xxxxxx, the patient was evaluated by, M.D., for complaints of right knee pain and swelling. Diagnosis was right knee meniscal tear and morbid obesity (**276 pounds**). The patient was maintained on Daypro, Celebrex and Lortab. She was also provided refill for phentermine.

On December 3, 2010, magnetic resonance imaging (MRI) of the right knee showed the following findings: (1) Advanced severe diffuse osteoarthritic changes with complex grade-3 tear of the body and posterior horn of the medial meniscus, which was extruded from the medial compartment. (2) Partial tear or strain of deep and superficial fiber of medial collateral ligaments including the meniscal capsular attachment. (3) Prominent suprapatellar effusion with superior lateral

plica synoviale. (4) Deep focal subchondral contusions or edema in the weightbearing surface of the lateral femoral condyle and tibial plateau centrally.

2011: From March 25 through June 16, 2011, the patient was under the care of Dr.. It was noted that the patient was unable to bear weight on the right. Dr. administered injections of Kenalog, Celestone and lidocaine in the right knee x 4. The patient reported increase in pain. He had knee effusion which was aspirated.

In August, M.D., evaluated the patient for complaints of right knee pain. He noted that the patient has had intra-articular cortisone injections of the knee with no substantial relief. He had ongoing right knee pain, giving way and swelling. It was noted that the patient had extensive conservative treatment for his right knee with restricted activity, exercise and therapy, medication and multiple knee injections. He wore a knee brace and used a cane. Review of systems (ROS) was positive for high blood pressure, balance problems and numbness/tingling. Examination of the right knee showed moderate effusion, 2+ valgus opening of the knee on stress testing, pain over the medial collateral ligament (MCL), pain along the medial joint line, positive McMurray's test, crepitation of patellofemoral joint with some mild pain and instability of the right knee. Dr. assessed right knee medial meniscus complex tear with tear of MCL at meniscal-femoral junction, articular cartilage damage of the medial compartment. He recommended right knee arthroscopic surgery.

X-rays of the right knee showed minimal medial compartment narrowing with medial and lateral compartmental osteophytes. There was patellofemoral joint space narrowing laterally with prominent osteophytes.

On October 7, 2011, Dr. performed right knee arthroscopy with medial meniscectomy, chondroplasty of medial femoral condyle with debridement, open reconstruction of MCL instability with anterior tibialis tendon allograft reconstruction.

Postoperatively, the patient had monthly follow-ups with Dr.. He was recommended to continue wearing brace and keep his leg elevated when he had removed the brace when he was non-weightbearing. His sutures were removed. Dr. noted that the patient was recovering very well. He recommended starting physical therapy (PT) including range of motion (ROM) and muscle exercises.

From November 23, 2011, through January 23, 2012, the patient attended 12 sessions of PT at xxxxxx consisting of moist hot pack, interferential electrical stimulation and therapeutic exercises.

2012: On January 13, 2012, M.D., performed a required medical evaluation (RME) and opined that the patient (**5' 11"**, **265 lb**) was not at maximum medical improvement (MMI) as he would need additional therapy. He would take a long time for recovery as he had some pre-existing arthritis of his knee.

In February, the patient reported pain and swelling in the right knee. He had difficulty walking because of the pain and had collapsing episodes of the knee. He reported pain in the anterior and medial aspect of the right knee. Dr. assessed advancing traumatic arthritis of the knee with ligamentous instability. He administered injection of Marcaine and Depo-Medrol in the right knee.

From February 13, 2012, through March 2, 2012, the patient attended seven sessions of PT at consisting of moist hot pack, electrical stimulation, therapeutic exercises and neuromuscular reeducation.

Per chart note dated February 14, 2012, Dr. reviewed standing x-rays of the right knee as showing significant osteoarthritis that had developed from the work-related trauma. The patient had a malalignment of the femur and the tibia. There was medial offset of the femur over the tibia by 2 cm. There was significant narrowing of the medial joint space. There was osteophyte formation in the medial and lateral joint space area and significant narrowing of the patellofemoral joint. Loss of articular joint space in medial compartment was significant and moderate to severe in the lateral compartment.

On April 3, 2012, Dr. noted that the patient had right knee significant swelling and pain. He noted that the patient was wearing an unloader brace. Dr. recommended right total knee replacement.

Per utilization review dated April 18, 2012, the request for right total knee replacement and three days of inpatient stay was denied with the following rationale: *"The patient is status post right knee arthroscopy with medial meniscectomy, chondroplasty of medial femoral condyle with debridement, open reconstruction of medial collateral ligament instability with anterior tibialis tendon allograft reconstruction on October 7, 2011. He has undergone physical therapy and has been given injections with persistence of symptoms. As per April 3, 2012 report, he exhibits significant pain and swelling of the knee. Motor strength and deep tendon reflexes are intact. A recent clinical assessment with comprehensive physical examination indicating the patient's current BMI and functional limitations was not provided for review. Exhaustion and failure of response to other conservative measures including optimized pharmacotherapy in conjunction with rehabilitation efforts were not objectively documented through medication logs with VAS scoring. The radiologist's report of the latest standing x-ray was not submitted for review. Hence, the medical necessity of the request for right total knee replacement and, consequently, three days of in-patient stay cannot be certified at this time."*

Per reconsideration review dated April 24, 2012, the request for right total knee replacement and three days of inpatient stay was denied by, M.D., with the following rationale: *"I spoke with Dr. ' nurse, and discussed the case. She stated she would fax over BMI documentation, x-ray reports and documentation of failure of steroid injections. However, no additional documentation has been received at this time. This is a request for an appeal for one right total knee replacement and*

three days of in-patient stay. The previous determination was noncertified due to lack of documentation of exhaustion and failure of conservative treatment and radiologist's report. There was still no objective documentation regarding exhaustion and failure of response to evidence-based conservative modalities such as PT and medications. The patient has had several PT sessions that provided improvement. The medication logs with VAS scoring were still not stated. The radiologist's report of the standing x-ray done was not provided. The current BMI of the patient was not provided in the most recent report. As per referenced guidelines, increased BMI causes increased risks for postoperative complications. Hence, the previous determination is upheld. Consequently, the request for hospital stay is not substantiated."

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

Documentation supports this claimant has had non-operative treatment including injections and medication. Standing x-rays do show osteoarthritis. The patient is noted to have a height of 5' 11" tall and weighs 265 pounds. The BMI is 37. This does not meet the criteria for total knee replacement. There is no documentation on a weight loss program. This is why this decision has been upheld to not certify the request for right total knee replacement.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES