

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: May 30, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Total Knee Arthroplasty with 3 Days Inpatient Stay (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)

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a work related injury on xx/xx/xx. At that time, he was xxxxx when he fell and landed on his right heel. He initially reported

acute right heel and knee pain and was treated with anti-inflammatories and some therapy.

On March 5, 2002, the claimant was evaluated by MD for persistent right knee pain. X-rays of the right knee and calcaneus were essentially unremarkable with well-maintained joint spaces and no obvious fractures. On physical examination of the right knee there was no obvious effusion. No patellar or prepatellar pain or crepitation was noted. He did have some mild medial joint line tenderness. No ligamentous instability. Negative Lachman's and negative anterior/posterior drawer test. Diagnosis: Sprain medial collateral ligament and Contusion of foot. Plan: Place the patient in a fracture boot and initiate therapy for quadriceps/hamstring exercises.

On April 24, 2002, the claimant was re-evaluated by, MD who reported he was completing physical therapy and was overall doing well. He was returned to regular work and instructed to continue on anti-inflammatory Bextra just as needed.

On May 21, 2012, Dr. opined that the claimant had reached maximum medical improvement as of May 15, 2002 with a 2% whole person impairment.

On September 11, 2002, the claimant returned to Dr. with persistent pain over the medial aspect of his right knee. On physical exam he had full ROM and ligamentous exam showed a stable knee. He did have tenderness over the medial joint line. Diagnosis: Sprain medial collateral ligament and possible tear medial meniscus knee, current. Plan: A MRI of the right knee was order.

On September 16, 2002, MRI of the Right Knee, Impression: 1. Medial compartment: Tear of the posterior horn of medial meniscus extending to the inferior meniscal margin with changes of chondromalacia. 2. Chondromalacia of the lateral compartment. 3. Signal changes are seen in the cartilage of the medial patellar facet.

On September 20, 2002, the claimant was re-evaluated by MD following the MRI. Diagnosis: Tear Medial Meniscus Knee. Because there was no catching or locking symptoms of the knee, Dr. recommended treating conservatively and just continuing on the anti-inflammatories.

On October 25, 2002, Dr. reported that the claimant had reached maximal medical improvement as of October 23, 2002 with a 4% whole person impairment. It was noted that the claimant was retired and was not required to work.

On June 11, 2003, the claimant returned to Dr. with complaints of having a little more pain in his right knee with intermittent swelling. On physical exam he showed mild synovial swelling in the right knee and there may have been a small effusion. He was tender over the medial joint line. His knee was stable, but he

did have some intermittent clicking in his knee. Dr. recommended a diagnostic arthroscopy.

On June 26, 2003, operative report by MD. Postoperative Diagnosis: 1. Medial meniscal tear of the posterior third complex with horizontal/vertical components. 2. Grade II extended area of grade III chondromalacia of the medial femoral condyle extending into a small area anterior over the weightbearing area 1x1 centimeter full thickness articular cartilage loss. 3. Lateral femoral chondromalacia area of central weightbearing grade IV chondromalacia roughly x 1 centimeter. Procedures: Examination under anesthesia and diagnostic arthroscopy with arthroscopic total medial meniscectomy, medial femoral chondroplasty with microfracture, lateral femoral chondroplasty with microfracture.

On June 30, 2003, the claimant was re-evaluated by MD postoperatively. He was reported to be doing well. He was placed on touchdown weightbearing and home CPM.

On July 2, 2003, the claimant had a physical therapy evaluation by, AT who recommended therapy three times per week.

On August 25, 2003, the claimant was re-evaluated by MD who reported he was two months post-op and continued to show improvement. His therapy had terminated just as he was starting the conditioning portion. A conditioning program for four more weeks was recommended.

On September 22, 2003, the claimant was re-evaluated by MD who reported he had finished therapy and was doing generally well with only a mild ache in the medial aspect of his knee. On physical examination he showed full range of motion with no effusion. Tenderness was noted over the medial joint line, but very mild. He was to continue with independent stretching and strengthening program.

On September 15, 2004, the claimant was re-evaluated by MD for intermittent soreness in the knee. He was continued on Mobic and allowed to do low impact exercises.

On December 15, 2004, the claimant was re-evaluated by MD who repeated x-rays which showed a little bit of narrowing of the medial compartment on the right as compared to the left.

On May 15, 2006, the claimant was re-evaluated by MD who reported that claimant's right knee was continuing to bother him and he just needed some anti-inflammatories. X-rays showed some narrowing of the medial compartment. His Mobic was renewed and Dr. discussed that his knee would probably progress on to a degenerative knee.

On March 5, 2007, the claimant was re-evaluated by, MD who performed x-rays which revealed approximate 50% cartilage loss of the medial compartment of the right knee as compared to the left.

On February 7, 2008, the claimant was re-evaluated by MD who performed x-rays which showed further narrowing of the medial compartment cartilage. An unloader brace was recommended and he was prescribed Celebrex.

On December 15, 2008, the claimant was re-evaluated by MD who performed x-rays which showed medial compartment narrowing, but no progression.

On May 11, 2009, the claimant was re-evaluated by, MD who renewed his Norco and ketoprofen cream prescription. He was also to use his brace as needed.

On January 24, 2010, MD performed a Peer Review. The following opinions were rendered: Current status is status post arthroscopic total medial meniscectomy, medial femoral condyle chondroplasty with microfracture, and lateral femoral chondroplasty with microfracture in 2003 accepted as related to the work event. The operative findings identified advanced chondromalacia at the time of the surgery in the lateral femoral condyle at Grade IV and Grade II to III in the medial femoral condyle. While these findings in all probability pre-existed the work event, the claimant had surgery for these degenerative findings that was accepted as related to the work event. In addition, the operative report identified that he also had a total meniscectomy. The peer reviewed literature has identified this type of procedure to accelerate the degenerative process. Per the above, it is more probable than not that the ongoing symptoms are causally related to the 2/18/02 work event, resulting in aggravation/acceleration of pre-existing chondromalacia. Occasional follow up for acute exacerbation in symptoms, or for renewal of prescription medication, is reasonable. Annual x-rays are reasonable. Depending on exam findings, occasional use of steroid injection would be reasonable. No active treatment is reasonably required at this time. The claimant may require a total knee replacement in the future as related to the accepted degenerative changes.

On March 22, 2010, the claimant was re-evaluated by, MD who reported he was still having pain in his knee. X-rays showed that he had significant collapse in his medial compartment consistent with his injury at work. On physical exam he had good mobility of the knee and there was synovial swelling with tenderness medially. He was given anti-inflammatories for pain control and Dr. opined that he would need a knee replacement in the future.

On December 9, 2010, the claimant was re-evaluated by MD who reported he was still having pain over the medial aspect of his knee and if it was bad enough he wanted a knee replacement. On exam he was intensely tender over the medial joint line. X-rays showed medial compartment collapse with almost complete cartilage loss. Medications were renewed.

On May 12, 2011, the claimant was re-evaluated by MD who reported he was having aggravation of discomfort with activities. On exam he showed good ROM, but lacked full flexion with tenderness along the medial joint line. He had a little bit of varus knee. His knee was stable. Diagnosis: unspecified internal derangement of knee, tear of medial cartilage or meniscus of knee, osteoarthritis unspecified whether generalized or localized involving lower leg. He was placed on Naprelan 500 mg.

On October 11, 2011, the claimant was re-evaluated by MD who reported he was having more and more trouble. On exam, he showed synovitis and tenderness over the medial compartment. Total knee replacement was recommended.

On March 19, 2012, the claimant was re-evaluated by, MD who reported he was having more and more pain in his right knee and that he would like to proceed with surgery. On exam he showed synovitis with tenderness medially. X-rays showed bone-on-bone medial collapse. Diagnosis: Osteoarthritis unspecified whether generalized or localized involving lower leg. Dr. recommended total knee replacement.

On April 5, 2012, MD performed a UR on the claimant. Rationale for Denial: The patient is status post injury to the right knee as of 2002. The patient subsequently had operative repair of that injury in 2003. There is much clinical documentation submitted for review; however, there was no indication that the patient has recently exhausted conservative measures for this injury. The clinical documentation indicated the patient had physical therapy status post operative repair of his knee in 2003. Additionally, the most recent clinical document submitted for review did not indicate subjective or objective clinical findings indicated for arthroplasty. This would include limited range of motion, night time joint pain, no relief with conservative care, and documentation of current functional limitations demonstrating necessity of intervention. Additionally, there is no indication of the patient's body mass index. The patient has not had MRI imaging of the right knee since 2002. The clinical documentation submitted does not indicate that the patient has had any kind of recent viscosupplementation injections or steroid injections to the knee. The current documentation submitted lacks evidence to support the current request. As such, the request for right total knee arthroplasty with 3 days inpatient stay is non-certified.

On April 16, 2012, the claimant was re-evaluated by MD who reported that the reason there is no documented recent conservative treatment is because the claimant had it in the past. "This has gone on to give him more and more problem as time has gone by. He knows what conservative treatment is available and is elected not to have it." Dr. further reported that the claimant wished to proceed with the knee replacement and that they will probably need to document more conservative treatment. The claimant is not sure he wants to do that and may look to have his knee replaced under Medicare.

On April 24, 2012, MD performed a UR on the claimant. Rationale for Denial: The documentation submitted for review elaborates the patient complaining of ongoing right knee pain. The ODG recommends a knee arthroplasty provided the patient meet specific criteria completion of conservative care, significant clinical findings, as well as imaging studies confirming osteoarthritis. The documentation details the patient having undergone extensive PT in 2003. However, there is a lack of information regarding the patient's pharmacological interventions and previous injections. Additionally, there is a lack of information regarding the patient's recent range of motion findings. There was a lack of information regarding the patient's BMI status. Given the lack of information regarding the patient's recent completion of conservative care and taking into account the lack of information regarding the patient's functional limitations and current BMI status, this request does not meet guidelines. The documentation does not support this request.

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

The previous decisions are upheld. The claimant was injured on xx/xx/xx and was treated conservatively. On June 26, 2003 he underwent surgical repair followed by a course of post surgical physical therapy. He was relatively functional for years with mild complaints of pain. His knee has progressively degenerated since the work related injury and surgical treatment. The claimant is complaining of more right knee pain and X-rays as of March 19, 2012 show bone-on-bone medial collapse. The request is for a Right Total Knee Arthroplasty with 3 Days Inpatient Stay (27447). ODG criteria for knee joint replacement includes Conservative Care, Subjective Clinical Findings, Objective Clinical Findings, and Imaging Clinical Findings. Although multiple medical records were submitted and reviewed there was a lack of documentation reporting limited range of motion, nighttime joint pain, lack of pain relief with conservative care, and current functional limitation demonstrating necessity of intervention. The claimant was taking medication including anti-inflammatories, but there was no documentation that a trial of Visco supplementation injections or Steroid injections were attempted to help alleviate pain. The claimant's Body mass Index was also not indicated within the recent records. Due to the lack of clinical findings, including BMI, and lack of documentation of recent conservative care including injections, the request for Right Total Knee Arthroplasty does not meet ODG criteria and therefore, is denied. Since the surgery is denied, the 3 Days Inpatient Stay (27447) would be irrelevant and also denied.

Per ODG:

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 AND Documentation of current functional limitations demonstrating necessity of intervention. 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)

ODG hospital length of stay (LOS) guidelines:

Knee Replacement (*81.54 - Total knee replacement*)

Actual data -- median 3 days; mean 3.4 days (± 0.0); discharges 615,716; charges (mean) \$44,621

Best practice target (no complications) -- *3 days*

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)**