

# CASEREVIEW

8017 Sitka Street  
Fort Worth, TX 76137  
Phone: 817-226-6328  
Fax: 817-612-6558

## Notice of Independent Review Decision

[Date notice sent to all parties]: January 5, 2015

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Total Knee Replacement with 3 Days Inpatient Stay

### 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 13 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 medical necessity exists for each of the health care services in dispute.

### PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx. Her right knee hit a metal door and the claimant states her right knee popped and then she felt immediate pain. Her past medical history includes in 2006 and 2007 undergoing partial lateral meniscectomy and Chondroplasty lateral femoral condyles. She did okay with this, but never did really great. She was initially diagnosed with right knee internal derangement and right knee sprain. She was prescribed Motrin 800 mg and Flexeril 10 mg and sent to physical therapy. She was also given a hinged knee brace to wear while at work with restrictions. Following initial PT with no relief, a MRI was ordered. Based on the results, she was referred to an orthopedic surgeon who recommended surgery. Following surgery she completed post-op PT.

On April 2, 2013, MRI Right Knee, Impression: Complex degenerative tears of the lateral meniscus anterior horn and body. Regions of articular cartilage loss

along the weight bearing aspect of the lateral femoral condyle with extensive adjacent bone marrow edema. Small joint effusion. The cruciate ligaments and collateral ligaments appear intact.

On April 24, 2013, Right Knee 4 Views, Impression: Chronic findings as above without acute abnormality. Findings: Mild osteophytosis is now present about the knee. Button osteophyte of lateral femoral condyle. Joint spaces are preserved with weight bearing. There is mild lateral patellar tilt on the merchant projection. No acute fracture or joint capsular distention.

On May 20, 2013, Operative Report. Postoperative Diagnosis: 1. Lateral meniscus tear, right. 2. Stable small grade 4 chondral lesion, lateral femoral condyle. Operations Performed: 1. Exam under anesthesia. 2. Arthroscopy, right. 3. Partial lateral meniscectomy.

On November 23, 2013, MRI Right Knee, Impression: 1. Findings suggesting post meniscectomy changes anterior horn lateral meniscus. 2. Advanced degenerative changes lateral compartment with articular cartilage loss along the weight bearing portion of the joint with subsequent degenerative spurring, subchondral sclerosis and adjacent bone marrow edema. Small subchondral cyst is also seen in the posterior aspect of the lateral femoral condyle. 3. Moderate sized joint effusion. Small Baker's cyst is also noted. 4. Cruciate and collateral ligaments appear to be intact.

On December 24, 2013, the claimant was evaluated for continued right knee pain. It was reported she had over 20 visits of PT without relief. Complaints included popping, clicking, locking, and giving out. She was still wearing a knee brace and walked with a limp. Current medications included Ibuprofen 800 mg, Cyclobenzaprine 10 mg. On examination of the right knee there was trace effusion, diffused soft tissue swelling. There was medial joint line tenderness with palpation and lateral joint line tenderness. Positive McMurray. ROM was limited due to pain. Assessment: 1. Sprain of knee. 2. Body Mass Index 40.0 – 44.9, adult. Plan: Injection with 10 cc lido/cortisone. Patient tolerated procedure.

On December 31, 2013, the claimant was re-evaluated who reported the cortisone injection gave only minimal temporary relief. She also report PT was not helping. Plan: Recommended diagnostic arthroscopy.

On February 11, 2014, Operative Report. Postoperative Diagnosis: Partially torn anterior cruciate ligament, partially torn medial and lateral meniscus, complete 3 compartment synovitis. Operation: Right knee diagnostic arthroscopy with ACL augmentation, partial medial and lateral meniscectomy, complete synovectomy.

On June 17, 2014, the claimant was re-evaluated for continued right knee swelling and complaints that her knee pops more. She had been doing her HEP. On examination there was trace effusion, diffuse soft tissue swelling. Palpation caused diffused medial tenderness and diffused lateral tenderness. ROM was limited due to pain. Plan: Injection of 10 cc lido/cortisone. Order MR Arthrogram.

On July 8, 2014, Right Knee Arthrogram, Impression: 1. Technically successful MR arthrogram of the right knee. 2. A post arthrogram MRI of the right knee will be obtained and dictated as a separate report.

On July 8, 2014, MRI of the Right Knee, Impression: 1. Evidence of previous surgery in the right knee with suggestion of partial lateral meniscectomy. 2. No gross recurrent meniscal tears are identified within the residual meniscus. 3. Tricompartmental osteoarthritis most severe in the lateral joint compartment. 4. Possible ACL sprain or previous injury.

On July 18, 2014, the claimant was re-evaluated who reported increasing pain and grinding. On exam there was full flexion and extension with mild crepitus with motion. Plan: PT has post traumatic chondromalacia, recommend Synvisc One injection.

On August 21, 2014, the claimant was re-evaluated for continued complaints of popping, clicking and grinding. Medications included ibuprofen 800 mg, cyclobenzaprine 10 mg, and Naprosyn 375 mg. BMI was indicated as 38.0 – 38.9. Procedure: Synvic One injection. Plan: If no relief, consider TKR.

On September 18, 2014, the claimant was re-evaluated who reported the Synvisc One injection gave minimal relief. Complaints of continued pain and grinding, walking with a limp. On examination, Height 67", Weight 238, BMI 37.27. Inspection of the right knee demonstrated trace effusion, diffused soft tissue swelling. On palpation there was diffused medial and lateral tenderness. ROM was limited due to pain with mild crepitus with motion. Plan: PT has post traumatic chondromalacia from a work injury; has tried and failed conservative treatment consisting of PT, cortisone injections, visco injection, bracing and activity modification; she has lifestyle limiting symptoms; recommend total knee replacement.

On October 15, 2014, UR. Rationale for Denial: The patient is a individual who sustained an injury on xx/xx/xx. Prior treatments included undated medications, ice therapy, physical therapy (PT) and injection with no relief. The patient had orthotics, but still complained of plantar fascial pain that had not been resolved. There seems to be some confusion since the request is for a TKA and not a plantar fasciotomy. Further conservative care for the plantar fasciitis is in order. Due to the confusion with this referral, the request for a right total knee replacement with 3 day inpatient stay with clinical reports reviewed dated through 09/18/2014 is not medically necessary or appropriate.

On November 19, 2014, UR. Rational for Denial: According to ODG guidelines regarding indications for surgery require: Conservative care, subjective clinical findings, objective clinical findings and imaging clinical findings. In this case, the patient has body mass index greater than 37. There is a high risk for postoperative complication requiring revision surgery. There was grade II, III chondromalacia of lateral compartment. There was no evidence of extensive

arthritis. The patient has had injection, medication, activity modification. In a peer to peer conversation the treating provider had no additional information. The 3 day inpatient stay is not warranted due to the non-certification of the surgery. Therefore, right total knee replacement with 3 day inpatient stay is not medically necessary and appropriate.

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

Based on the records reviewed, there is inadequate documentation to support a knee replacement in this patient.

The patient has documented osteoarthritis on her imaging studies. The November 2013 MRI report indicated "complete loss of cartilage in the weightbearing portion of the lateral femoral condyle." The July 2014 MRI documented tricompartmental osteoarthritis, most severe in the lateral compartment.

She has undergone two arthroscopic procedures following her work injury. She has completed a course of conservative care consisting of physical therapy, cortisone injection and viscosupplementation.

The Official Disability Guidelines (ODG) supports knee replacement for tricompartmental osteoarthritis upon completion of conservative care. Subjective and clinical findings should be documented. These include limited knee motion, with less than 90 degrees of flexion. Night-time joint pain should be documented. The patient should have no pain relief with conservative care. The patient should have functional limitations, which demonstrate the medical necessity of the knee replacement.

Although the patient has completed a course of conservative care for tricompartmental osteoarthritis, the ODG requirements for subjective and clinical findings have not been documented. The patient's functional limitations are not clearly reported in the medical record. Once these requirements are documented, the patient could be considered an appropriate candidate for knee replacement.

The request for 3 Day Inpatient Stay does meet ODG recommendations IF the surgery was medically appropriate, which is not at this time.

Therefore the request for Right Total Knee Replacement with 3 Days Inpatient Stay is not medically necessary at this time.

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:** Exercise therapy (supervised PT and/or home rehab exercises). AND Medications. (unless contraindicated: NSAIDs OR Visco supplementation injections OR Steroid injection). PLUS

**2. Subjective Clinical Findings:** Limited range of motion (<90° for TKR). AND Nighttime joint pain. AND No pain relief with conservative care (as above) 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 40, where increased BMI poses elevated risks for post-op complications. PLUS

**4. Imaging Clinical Findings:** Osteoarthritis on: Standing x-ray (documenting significant loss of chondral clear space in at least one of the three compartments, with varus or valgus deformity an indication with additional strength). OR Previous arthroscopy (documenting advanced chondral erosion or exposed bone, especially if bipolar chondral defects are noted). ([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 ( $\pm$  0.0); discharges 615,716; charges (mean) \$44,621

Best practice target (no complications) -- 3 days

**Revise Knee Replacement** (81.55 - Revision of knee replacement, not otherwise specified)

Actual data -- median 4 days; mean 4.8 days ( $\pm$  0.2); discharges 4,327; charges (mean) \$60,129

Best practice target (no complications) -- 4 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)**