

Becket Systems

An Independent Review Organization

815-A Brazos St #499

Austin, TX 78701

Phone: (512) 553-0360

Fax: (512) 366-9749

Email: manager@becketystems.com

Description of the service or services in dispute:

27486 – Left total knee arthroplasty revision with a two-day inpatient stay

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgery

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- Overturned (Disagree)
- Upheld (Agree)
- Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary): XXXX is a XX-year-old XX who was diagnosed with unilateral primary osteoarthritis of the left knee (M17.12) and presence of a right artificial knee joint (Z96.651). Per the records, the date of injury was XXXX, but no mechanism of injury was noted.

Per an evaluation on XXXX, it was noted he had continued pain in the left knee. He had undergone a total knee arthroplasty approximately 10 years prior and was having complications. The examination revealed some swelling. There was obvious clicking and locking on examination. There was pain to palpation over the medial and lateral aspects.

Treatment to date consisted of surgery.

X-rays of the knee on XXXX, revealed symmetric wear with more wear on the lateral than the medial side.

Per a utilization review determination letter dated XXXX, by XXXX MD (Orthopedic Surgery) the request for left total knee arthroplasty revision with a two-day inpatient stay was non-certified. The medical records provided for review showed that the patient had continued pain in the left knee. According to the guidelines, a total knee arthroplasty revision was recommended when there was objective medical evidence provided to support that a failure had occurred. The criteria included recurrent disabling pain, stiffness, and functional limitations that had not responded to appropriate conservative nonsurgical management to include exercise and physical therapy, fracture or dislocation of the patella, instability of the components or aseptic loosening, infection, or peri-prosthetic fractures. It was noted in the medical records that the patient was having continued pain, but there was no objective medical evidence provided to support that the patient had completed an appropriate conservative nonsurgical course of treatment to include exercises and physical therapy. Also, there was no diagnostic imaging made available for review to confirm failure of the already placed hardware from the previous total knee arthroplasty.

A utilization review letter dated XXXX (amended XXXX), by XXXX, MD indicated that the reconsideration request was denied as not medically necessary. Rationale: “The previous noncertification by Dr. XXXX on XXXX, was due to lack of exhaustion of lower levels of care and lack of imaging showing failure. The previous noncertification is supported. Additional records were not submitted for review. A total knee arthroplasty revision is recommended when there is evidence to support a failure has occurred. Records do not reflect lower

levels of care such as the use of NSAIDs, physical therapy, or a home exercise program. Records do not reflect imaging showing instability or aseptic loosening. Records do not reflect infection or prosthetic fracture.”

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The original denial should be upheld. There is insufficient information provided to establish medical necessity of the requested revision knee arthroplasty. Specifically, the radiographs reportedly show wear of the polyethylene insert, but there is no documentation indicating complete wear of the insert. The treating clinician does not delineate the specific cause for the ongoing symptoms or reported mechanical complaints. There is evidence of recurrent disabling pain, but no component failure, instability of the components, infection, or fracture. Guidelines require a trial of conservative treatment to include exercise and physical therapy for pain. Given the limited information that has been made available, the original denial should be upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers
- Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain
- Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment Guidelines
Knee and leg: revision total knee arthroplasty
Revision total knee arthroplasty
Recommended for failed knee replacement or internal fixation, as indicated below. Prostheses are generally very durable; however, failure sometimes does occur, requiring revision.
See Surgery for arthrofibrosis. For average hospital LOS if criteria are met, see Hospital length of stay (LOS).
Criteria for Revision total knee arthroplasty (TKA):
 - Recurrent disabling pain, stiffness, and functional limitation that has not responded to appropriate conservative nonsurgical management (exercise and PT);
 - Fracture or dislocation of the patella;
 - Instability of the components or aseptic loosening;
 - Infection;
 - Periprosthetic fractures.
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)