

# MATUTECH, INC.

**DATE OF REVIEW:** March 8, 2007

**IRO CASE #:**

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

Left knee medial/lateral meniscectomies with manipulation and ACL reconstruction

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

The physician providing this review is an orthopedic surgeon. The reviewer is national board certified in orthopedic surgery. The reviewer is a member. The reviewer has been in active practice for six years.

## **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**

Request for Independent Review

Information provided by M.D.:

Radiodiagnostics, MRI left knee  
Office notes (10/24/06 – 01/30/07)

Information provided by M.D.:

Office notes  
Radiodiagnostics, MRI left knee

DDE (02/09/06)

Information provided by:

Radiodiagnostics, MRI left knee  
Office notes (10/17/05 – 01/30/07)

**PATIENT CLINICAL HISTORY:**

The patient is a male who was climbing down stairway on a rig carrying a light pole when he stepped wrong on his left foot and felt a “pop” in his left knee.

In 2005, M.D., suspected left knee strain versus meniscal tear.

Magnetic resonance imaging (MRI) of the left knee was obtained, which revealed postsurgical changes from a previous anterior cruciate ligament (ACL) repair, joint effusion, tear of the posterior horn of the medial meniscus, tear of both horns of the lateral meniscus, and proximal patellar tendinosis. M.D., an orthopedic surgeon, was consulted who had treated the patient for a left knee injury back in 1994 or 1995 with an arthroscopy followed by an ACL repair. Later, the patient had also undergone hardware removal. Dr. obtained x-rays, which showed some medial compartment narrowing and small osteophytes. On examination, there was atrophy of the left quadriceps, knee effusion, and positive. Dr. felt it was impossible to ascertain whether the menisci changes were new or related to the old injury. However, he recommended arthroscopic surgery for possible debridement of the meniscus as well as the joint and reconstruction of the ACL. A request for surgery was denied in October 2005 with the following rationale: *Medical records suggested prior surgery for an ACL reconstruction. The MRI reports did not say that the ACL was absent. A positive Lachman's was not unusual after an ACL reconstruction as long as the pivot shift was negative. The meniscal findings might be postsurgical and there was no discussion regarding conservative treatment for rehabilitative efforts to verify that the claimant required a surgical reconstruction,* M.D., a designated doctor, assessed clinical maximum medical improvement (MMI) as of February 9, 2006, and assigned 0% whole person impairment (WPI) rating.

In October 2006, M.D., an orthopedic surgeon, reviewed x-rays and noted some postsurgical changes and mild arthrosis. He diagnosed medial meniscal and lateral meniscal tears of the left knee, injury of a prior ACL graft with instability, and flexion contracture of the left knee. He recommended arthroscopy with debridement and/or repair of the medial and lateral meniscal tears, revision ACL reconstruction, and attempted manipulation of the left knee to reduce flexion contracture. On November 30, 2006, surgery was denied with following rationale: *The request was not indicated for ACL reconstruction. While the claimant did have positive Lachman's, his MRI did not demonstrate an ACL tear. Request was indicated for medial and lateral meniscectomy which was reasonable and necessary. The request for manipulation under anesthesia was not directly addressed but was reasonable.*

On January 25, 2007, the appeal for the proposed surgery was again denied with following rationale: *The medical records were unclear whether this injury happened in 2005 or 2006. A pivot exam was not clarified to whether the ACL was insufficient. It was not unusual to have residual Lachman after a satisfactory ACL reconstruction. If this claimant had had an ACL insufficiency and had developed degenerative tearing as a result of instability, then the request for arthroscopic debridement of the meniscus would be appropriate. If this claimant did have joint contracture and was a candidate for manipulation to restore mobility, an ACL reconstruction at the same sitting might be contraindicated, for ACL reconstruction on a stiff knee would result in persistent stiffness and was an increased risk for arthrofibrosis. It appeared that if this claimant was truly having internal derangement symptoms and/or meniscal complaints, with locking, catching, giving way and not from pain just from a direct contusion injury, then the arthroscopy and indicated procedure would be helpful. It was unclear, however, the medical necessity for revision ACL reconstruction for a stiff knee and without knowledge of the stability or rotational resting, i.e., pivot exam.*

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

Review of the medical records shows he sustained a twisting injury in to his left knee that over time continued to be painfully symptomatic along both the medial and lateral joint lines. Subsequent to the injury he had an MRI performed that showed medial and lateral meniscal pathology, evidence of a joint effusion and post-surgical ACL changes. The radiologist was not particularly forthcoming about the exact appearance or presence of residual ACL fibers in his report of findings. The orthopedic surgeons who physically examined noted complete absence of the ACL on that same MRI, and based on history and physical recommended manipulation under anesthesia for his 10degree flexion contracture, debridement versus repair of the multiple meniscal tears and reconstruction of his ACL insufficiency. In their reports he is described as having a positive Lachman with no end point and a positive anterior drawer. Mention is made in that report of symptoms of giving way which the clinicians apparently posit to anterior cruciate instability. Surgical refusal has been upheld twice based on wording of the narrative and failure to adequately document the presence or absence of a pivot shift.

It is this reviewer's opinion that refusal for requested surgical treatment be upheld for the following reasons:

1. Specific clinical information needs to included in the narrative explaining that even though a pivot shift test was not able to be performed, by history the patient was experiencing instability in the knee with pivoting/cutting motions of that knee. If this were done, my recommendation would be to overturn the surgical refusal for ACL reconstruction. However, the information included in the clinic notes is just not sufficient at the time of this review to overturn the previously upheld denial.

2. The patient describes joint line pain but no mention is made in the history or physical exam of any mechanical symptoms or positive provocative meniscal tests respectively. Additionally, no mention is made by the radiologist or the orthopedic surgeon about how many sections the linear signal (tear) is seen and/or what grade signal is being visualized on the MRI performed. These documentation issues need to be addressed if refusal for surgical treatment is to be overturned.

3. The knee flexion contracture of ten degrees needs to be addressed with

appropriate conservative measures (serial passive stretching devices etc.) before accepting the need for surgical treatment. Additionally, addressing this concern with manipulation under anesthesia at the time of the ACL reconstruction is connected with increased risk of arthrofibrosis and should likely not be performed at the same setting.

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

**The guidelines utilized in arriving at recommendations for this case are based on well established standards recognized within the orthopedic community and supported by professional literature, training standards and experience. Additional referencing is taken from the National Guidelines Clearinghouse at HYPERLINK "<http://www.guidelines.gov/>"www.guidelines.gov.**