

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee arthroscopy TIT, re-release of lateral retinaculum, and medial tubercle repair.

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 of the American Academy of Orthopedic Surgeons. The reviewer has been in active practice for 20 years.

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

Department of Insurance

- Utilization reviews (02/18/08 – 02/25/08)

M.D.

- Office notes (05/12/06 – 02/11/08)
- Diagnostics (05/22/06 – 12/21/07)
- Surgical procedures (11/07/06 – 01/16/07)

Healthcare Corporation

- Office notes (02/11/08 - 04/07/08)
- Diagnostics (12/04/07 – 12/21/08)
- Utilization reviews (02/18/08 – 02/25/08)

ODG criteria utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old female who was injured on xx/xx/xx. She fell off of a ladder from about 5-6 foot height. This resulted in fracture dislocation of left mid foot and substantial amount of contusion over the anterior aspect of her left knee.

On May 12, 2006, M.D., evaluated the patient. *Following the injury, M.D., performed open reduction internal fixation (ORIF) of a Lisfranc fracture dislocation. The screws were placed through the first, second, and fourth tarsometatarsal (TMT) joints. No treatment was provided for the left knee. The patient had been in a fracture walker nonweightbearing on the left at the advice of her surgeon.* Examination revealed a positive McMurray's test and tenderness over the medial joint line on the left. There was some discomfort with patellofemoral manipulation. There was tenderness around the left ankle diffusely. X-rays revealed some rarification of the talus, due to possible reactive osteoporosis. There was a bit of a diastasis between the medial and intermediate and probably the lateral and intermediate cuneiforms. The second, third, and fourth metatarsals were not perfectly parallel. Dr. recommended physical therapy (PT) for the metatarsophalangeal (MTP) joint stiffness.

Magnetic resonance imaging (MRI) arthrogram of the left knee revealed mild diffuse narrowing of the articular cartilage and mild prepatellar and infrapatellar bursitis. Dr. stated that the MRI arthrogram did not document reason for early intervention. The patient stated that her knee was giving problem with squatting exercises. Dr. prescribed Relafen. X-rays of the left foot revealed retained screws without migration of the TMT joint and early narrowing of the TMT joints. X-rays of the left ankle showed some regional disuse osteoporosis. On November 7, 2006, Dr. performed left ankle arthroscopy and debridement of the anterior inferior talofibular ligament and removal of the first, second, and fourth metatarsal hardware.

The patient did well in respect to his left foot. Dr. prescribed TED Jose and custom shoe. However, the patient continued to have left knee problems. On January 16, 2007, Dr. performed left knee arthroscopy and lateral retinacular release, medial femoral, and patellofemoral chondroplasty, and excision notch spur. The postoperative findings were left patellar and trochlear chondral tearing, medial femoral chondral tearing, patellar subluxation, and notch spur. The patient was struggling with her flexion and was put in physical therapy (PT) and home exercise program (HEP). X-rays revealed arthritic changes over the TMT joints. Dr. informed the patient that her left foot would continue to bother her all of her life and it would limit her substantially. Additionally, she was going to develop probably progressive degenerative changes in her TMT joints and would require a life time supports and custom shoes, and probably revision surgery from time to time. The patient later went to work hardening program (WHP) and return to full duty in July 2007.

In December 2007, MRI of the left knee revealed: (1) Minimal fluid within the retropatellar joint space. (2) Partial thickness to full thickness tear of the proximal to intermediate zone of the anterior cruciate ligament (ACL). (3) Ligamentous strain of the intermediate zone of the posterior cruciate ligament (PCL). (4) Shallow partial thickness tear of the posterior horn of the medial meniscus associated with infra-articular extension. (5) Tendinosis/tendinopathy of distal quadriceps tendon. Medial collateral ligamentous strain and reparative change. Dr. stated that the patient had

some increased discomfort in a left knee over the last three weeks when she felt a pop over the medial side of her knee while turning. He felt there was a possible extension of previously known medial meniscus insufficiency. MR arthrogram of the left knee revealed cartilage irregularity involving the medial compartment of the knee and the patellofemoral compartment, mild prepatellar bursitis, and increased signal in Hoffa's fat pad representing focal edema or injury. Dr. recommended treatment with anti-inflammatories and a strengthening program.

In February 2008, Dr. noted a weakly positive McMurray's test and tenderness over the medial joint line. Patellofemoral manipulations lead to significant discomfort in lateral subluxation. He assessed intermediate result from chondroplasty and lateral release of the left knee cap with residual left patellofemoral subluxation and probably some degree of extension of patellofemoral chondral tearing. He requested left knee arthroscopy TIT and re-release of lateral retinaculum, medial transfer of the tibial tubercle, and possible medial retinacular release.

On February 18, 2008, request for the left knee arthroscopic TIT, re-release of lateral retinaculum, and possible medial retinacular repair was denied with the following rationale: *The December 4, 2007 MRI showed normal alignment without any retinacular abnormality or meniscal tear. She has some irregularity of the chondral surface. There was no official MRI arthrogram report forwarded. Thus the request is not validated by these records. A required medical evaluation (RME) would be reasonable before proceeding to further surgeries.*

An appeal for the left knee surgery was denied with the following rationale: *The medical records revealed that this claimant had arthroscopy in January 2007 and had an incident with recurrent anterior knee pain. Recent diagnostics revealed chondral surface irregularities with prepatellar bursitis, but no changes to suggest injury or inflammation. It is unclear of the medical necessity for repeat knee surgery for the anterior knee pain. Recent study suggests that an exercise program is as effective as surgical management. There is no suggestion that a patella is subluxed on these recent reports.*

In March, D.C., treating physician, stated that the patient still had positive findings in the left knee area and was losing muscle tone in her quadriceps and abductors. Her ROM continued to decrease. He stated that the requested PT and rehab had been denied. He stated that the surgical intervention was medically necessary and appropriate as recommended by Dr.. Dr. opined that the symptoms in the left knee were directly caused by the injury of March 1, 2006 and arthroscopic reevaluation of the left knee with re-release of the lateral retinaculum with possible medial retinacular repair and tibial tubercle transfer was a reasonable step.

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

Per ODG, there are no imaging studies such as x-ray, CT and/or MRI that show malalignment of the patella that would require another lateral retinaculum or tibial tubercle transfer.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES