



Medical Review Institute of America, Inc.
America's External Review Network

Amended review 2/13/09

DATE OF REVIEW: February 10, 2009

IRO Case #:

Description of the services in dispute:

Left knee biopsy soft tissue.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Orthopaedic Surgery. This reviewer is a member of the American Academy of Orthopaedic Surgeons and the Society of Military Orthopaedic Surgeons. This reviewer has been in active practice since 2005.

Review Outcome

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

Overtured

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.

The left knee cyst excisional biopsy is medically necessary.

Information provided to the IRO for review

Records Received State:

IRO Request Form – 7 pages

Review Summary – dated 12/11/08 – 3 pages

Review Summary – dated 11/25/08 – 3 pages

Notice of Utilization Review Agent of Assignment of IRO dated 1/27/09 – 1 page

Preauthorization – Intake form – 1 page

MRI of left knee dated 10/15/08 – 2 pages

Follow up note dated 10/23/08 – 1 page

Follow up note dated 9/25/08 – 1 page

Patient Referral – 2 pages

Authorization request for therapy – 1 page

Therapy Prescription form – 1 page

Physical Therapy Evaluation dated 5/6/08 – 1 page

Doctor's First Report dated 2/26/08 – 1 page

MRI of left knee dated 3/10/08 – 2 pages

Doctor's First Report dated 3/20/08 – 1 page

Patient Referral – 1 page

Patient clinical history [summary]

The patient is a xx year-old male with an injury to his left knee on xx/xx/xx when he slipped on the floor. An MRI showed a medial meniscal tear and a large posterior cyst. He had left knee pain and ultimately underwent left knee arthroscopy on 4/30/08 with a partial medial meniscectomy. Since surgery, his follow up notes state his meniscal pain has improved however he continues to complain of posterior gastroc pain and pressure. A repeat MRI shows no evidence of a new meniscal tear, moderate proximal patella tendinitis, small joint effusion, medial femoral condyle surface irregularity/degeneration of articular cartilage, and a large posterior cyst that is stable from the earlier MRI images and a new small cyst in the PCL. The patient has a past history of a prior medial meniscal repair in 2005 followed by an arthroscopy with drainage of the cyst in 11/2006. Dr hoped that treating the intraarticular meniscal pathology would allow the cyst to resolve, however it has not, and it is now painful. He is now recommending an excision of the left knee cyst.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The patient's history is consistent with the development of a Baker's cyst. A Baker cyst, also called a popliteal cyst, is swelling caused by knee joint fluid protruding to the back of the knee (popliteal area of the knee). When an excess of knee joint fluid is compressed by the body weight between the bones of the knee joint, it can become trapped and separate from the joint to form a fluid-filled sac, referred to as a Baker cyst.

This patient's history of multiple medial meniscal tears and damage to the articular cartilage is the likely source of the Baker's cyst. He has had the normal treatment with an aspiration of the cyst, and three knee surgeries to address the intraarticular pathology. (Curl 1996, Sansone 1999, Rupp 2002) Despite these treatments his cyst has not resolved and is now painful. Thus his diagnosis is a recurrent Baker's cyst. In these rare cases sometimes cyst excision is necessary. Curl 1996 recommends cyst excision with the need for removal of the stalk that leads from the cyst to the joint. The need for surgical excision of recurrent cysts, although rare, is also supported in the literature. (Medvecky 2005, Handy 2005, Ko 2004, Ahn 2007, Takahashi 2005) Calvisi 2007 recommends an arthroscopic technique with suture closure of the valve to the cyst. There is still a

chance that despite surgical excision, the cyst could recur given that he has degeneration of his articular cartilage which could lead to persistent swelling.

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

The ODG knee chapter does not address recurrent Baker's cysts.

WW Curl

Popliteal Cysts: Historical Background and Current Knowledge

J. Am. Acad. Ortho. Surg., May 1996; 4: 129 – 133.

Handy JR.

Popliteal cysts in adults: a review.

Semin Arthritis Rheum. 2001 Oct;31(2): 108–18. Review.

Sansone V, De Ponti A.

Arthroscopic treatment of popliteal cyst and associated intra-articular knee disorders in adults.

Arthroscopy. 1999 May;15(4): 368–72.

Ko S, Ahn J.

Popliteal cystoscopic excisional debridement and removal of capsular fold of valvular mechanism of large recurrent popliteal cyst.

Arthroscopy. 2004 Jan;20(1): 37–44.

Rupp S, Seil R, Jochum P, Kohn D.

Popliteal cysts in adults. Prevalence, associated intraarticular lesions, and results after arthroscopic treatment.

Am J Sports Med. 2002 Jan–Feb;30(1): 112–5.

Calvisi V, Lupporelli S, Giuliani P.

Arthroscopic all-inside suture of symptomatic Baker's cysts: a technical option for surgical treatment in adults.

Knee Surg Sports Traumatol Arthrosc. 2007 Dec;15(12): 1452–60. Epub 2007 Aug 1.

Ahn JH, Yoo JC, Lee SH, Lee YS.

Arthroscopic cystectomy for popliteal cysts through the posteromedial cystic portal.

Arthroscopy. 2007 May;23(5): 559.e1–4. Epub 2007 Jan 5.

Takahashi M, Nagano A.

Arthroscopic treatment of popliteal cyst and visualization of its cavity through the posterior portal of the knee.

Arthroscopy. 2005 May;21(5): 638.

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