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Notice of Independent Review Decision

DATE OF REVIEW: 10/7/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of arthroscopic ACL repair/Augmentation/Reconstruction (29888).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of arthroscopic ACL repair / Augmentation / Reconstruction (29888).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
, MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from , MD: MRI report – 7/27/09; MRI & MRI report – 2/9/09, MRI report – 2/9/09; report – 3/10/09(x2); , MDDME script –

3/9/09, Patient Profile – undated, Office Notes – 3/18/09-8/22/09; TMC Orthopedic brace script – 7/29/09; Verification of Physician Visit – 4/13/09 & 7/22/09, Fitness for Duty Certification – 4/13/09 & 7/17/09; US Dept of Labor form WH-380-E – 3/9/09; Pre-Op instructions – undated; PT Progress Report – 5/18/09, PT Evaluation – 4/30/09; Referral Form – 4/22/09. Records reviewed from : Denial Letter – 9/2/09 & 9/11/09; email to ‘physician report’ – 9/11/09; email to – 9/3/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male . He was injured at work when he mis-stepped, injuring his right knee. Records presented do not note an acute hemarthrosis at the time of injury. The patient complains of pain, but records do not reflect subjective instability or “giving way” of the knee. The patient has instability demonstrated by positive Lachman’s test and a positive pivot shift test. MRI is compatible with a torn ACL.

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

This patient meets the criteria for ACL reconstruction in each category except documentation of subjective instability.

According to the ODG: ACL reconstruction:

1. : Brace. PLUS
2. : Pain alone is not an indication for surgery. Instability of the knee, described as "buckling or give way". PLUS
3. Objective Clinical Findings (*in order of preference*): Positive Lachman's sign. OR Positive pivot shift. 4. Imaging Clinical Findings: ACL disruption on: Magnetic resonance imaging (MRI)

Since there is no documentation of subjective instability at this time, this procedure is not medically necessary.

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)**