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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 04/06/2010

IRO CASE #:

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

This case was reviewed by a Orthopaedic Surgery, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right knee revision of ACL reconstruction partial meniscectomy medial lateral synovectomy; chondroplasty; patellar tendon autograft with 2 day LOS

REVIEW OUTCOME

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

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 04-04-08 Operative report from Dr.
- 07-14-08 PT Plan of Care from, PT
- 07-14-08 PT Progress Evaluation from, PT
- 11-04-08 MRI right knee as read by Dr.
- 12-09-08 Initial Evaluation report from Dr.
- 01-12-09 Operative Report from Dr.
- 01-20-09 Post-op Follow-up report from Dr.
- 02-17-09 Post-op Follow-up visit report from Dr.
- 03-19-09 Post-op Follow-up report from Dr.
- 10-12-09 Initial examination report from Dr.
- 10-19-09 Final Radiology report read by Dr.
- 10-26-09 Medical report from Dr.
- 10-28-09 Follow-up Medical report from Dr.
- 11-11-09 Follow-up Medical report from Dr.
- 12-01-09 Follow-up Medical report from, PAC
- 12-18-09 Follow-up Medical report from, PAC
- 01-04-10 Radiology report, MRI knee read by Dr.
- 01-15-10 DWC form 72 from Dr.
- 01-15-10 Follow-up Medical report from Dr.
- 02-01-10 Medical Report from Dr.
- 02-05-10 Follow-up Medical report from, PAC
- 02-05-10 Preauthorization request, unsigned.

- 02-05-10 Initial Adverse Determination letter
- 02-09-10 Radiology report, knee x-rays read by Dr.
- 02-23-10 Preauthorization request for Worker's Comp from Dr.
- 03-01-10 Request for treatment needs.
- 03-12-101 Preauthorization request for Synvisc injections from the patient's attorney
- 03-03-10 Adverse Determination letter on reconsideration
- 03-16-10 Preauthorization request.
- 03-19-10 Request for IRO from the Claimant
- 03-24-10 Notice of Case Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female employee who sustained an industrial injury to the right knee on xx/xx/xx. MRI showed ACL rupture and intact menisci. Due instability it was decided to do a surgery. She is status post arthroscopic anterior cruciate ligament reconstruction with allograft bone tendon bone with femoral absorbable anchors on April 4, 2008 and is followed for persisting right knee complaints with a primary diagnosis of knee pain (719.46).

The patient re-initiated PT on July 14, 2009 for a sprain of the cruciate ligament and pain at the right knee. She twisted her knee. She has an allergy to aspirin. She smokes and has asthma. She was last seenin therapy on May 12, 2009. She is using a knee brace. Flexion is 05 to 100 degrees. She reports severe knee pain. 12 sessions are planned.

Right knee MRI of November 4, 2008 revealed reinjury to the ACL graft with a possible partial tear. The menisci, posterior cruciate ligament and collateral ligaments were intact. Stage II chondromalacia patella was noted.

The patient was seen post-op on December 9, 2008. X-rays were reviewed. She commented that the normal anterior tibial spine is gone on the x-ray on the right. The provider explained that that would be correct as it is necessary to drill through the spine in order to place the graft. This is a sacrifice in order to put the graft in place. She is smoking two or three packs daily and was advised to quit. An arthroscopy was discussed to remove a possible loose body at the graft.

On January 12, 2009 the patient underwent right knee arthroscopy for excision of a medial plica and debridement and partial anterior ligament tear.

Post-op 8 days the patient was doing well. She has lost 15 pounds and weighs 175 pounds. She has good range of motion of 0-120 degrees. PT will be crucial for good rehabilitation. At 36 days post-op the patient has range of motion of 0 - 135 degrees. She is attending therapy. There is no swelling and she uses the brace only for comfort. She can return to work without restrictions. 66 days post-op there is still some instability and the patient has increased pain with colder weather. She needs to be participating in a long-term conditioning program such as a stationary bicycle. She has reduced smoking to about half a pack daily.

The patient's symptoms and treatment during the period of March though October 11, 2009 are not covered by the submitted records.

The patient was provided a surgical consultation on October 12, 2009 for continuing right knee pain with popping and shifting. She attended three sessions of PT but stopped as her knee was buckling. She has had two surgeries. A cadaver graft bone tendon graft was used in the second surgery. Her pain management provider is recommending Synvisc injections. The MRI of November 2008 was reviewed. She is 5' 3" and 180 pounds. A partial ACL tear is suspected. Recommendation was for CT arthrogram.

CT scan was performed on October 19, 2009 for a knee that pops in and out of place and has very little strength. The patient has had two previous knee surgeries. Patient states, surgeon feels it never healed properly and suspects a return ACL. Small joint effusion was seen. There is mild lateral subluxation of the patella. There is narrowing of the medial and lateral compartments. The soft tissues are unremarkable. There is evidence of ACL reconstruction and will placed femoral and tibial tunnels. Graft impingement is difficult to assess on CT, consider MRI if there are concerns for graft impingement.

The patient was seen on October 26, 2009 to review the CT scan results. The graft is in place but graft impingement could not be assessed. They are not authorizing any more PT. She has failed conservative treatments. The patient was recommended arthroscopy with augmentation of ACL graft with Arthrocare (coblation device), and debridement of any torn ligament. Examination showed weak endpoint to anterior drawer test.

Pending a possible surgery, the patient was followed medically. On October 28, 2009 generalized swelling and restricted range of motion are noted. Naprosyn 550 mg is ordered. On November 11, 2009 she reported her left knee is giving way on her, most recently when she stepped off a curb. Crepitus and instability were noted. On December 1, 2009 she inquires regarding status of the recommended surgery. She is using Skelaxin, Darvocet and Naprosyn. On December 28, 2009 the patient reported she fell several days earlier and still has some swelling. Synvisc injections have been requested.

Repeat right knee MRI was performed on January 4, 2010 and given impression: Findings suggest near complete to complete ACL tear. There is evidence for chronic proximal LCL sprain without disruption and a marginal tear within the posterior horn of the lateral meniscus with degenerative changes within the posterior horn of the medial meniscus. It was noted that abnormal recent arthrogram suggests ACL re-tear.

The patient returned to her surgical provider on February 1, 2010 with her MRI films. They are interpreted to show complete ACL tear. She has had cadaver graft with plastic screws to fix the graft. She continues with pain and instability. Surgery was discussed as described as right knee revision of ACL, reconstruction, partial meniscectomy medial lateral; synovectomy, chondroplasty and patellar tendon autograft.

The patient was seen by her regular medical provider on February 5, 2010. The examination noted, generalized swelling, pain with movements, generalized tenderness, crepitus and unstable knee joint.

Radiographs taken of the knee on February 9, 2010 were given impression: Minimal degenerative narrowing without other significant degenerative changes about the patellofemoral and medial knee compartment. No other significant findings are demonstrated. The patient is status post ACL reconstruction. If clinical symptoms persists, MRI may be helpful for further

evaluation.
Knee surgery was requested for authorization on February 23, 2009.
Request for right knee revision of ACL reconstruction partial meniscectomy medial lateral synovectomy; chondroplasty; patellar tendon autograft with 2 day LOS was considered in review on February 5, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. Post-operative MRI suggested the graft was intact as did a CT scan, however, the provider noted the patient had a weak end point. No documentation of a positive Lachman's, a positive pivot shift or positive KT test were provided. The response to former PT is unclear, or if bracing was attempted. A recent MRI suggested a near complete ACL tear or chronic degenerative changes. The need for a 2-day length of stay is unclear. Given the above issues without the benefit of a peer discussion, the surgery and stay cannot be recommended at this time.
Request for reconsideration right knee revision of ACL reconstruction partial meniscectomy medial lateral synovectomy; chondroplasty; patellar tendon autograft with 2 day LOS was considered in review on March 3, 2010 with recommendation for non-certification. Six months prior the patient had undergone arthroscopic ACL reconstruction. An MRI of the right knee done in November 2008 documented findings that were suggestive of a reinjury to the right knee ACL. She was evaluated for PT in July 2009, however, the duration and response to the treatment is not known; there was notation of bracing at that time. An MRI of January 4, 2010 revealed findings of a near complete to complete ACL tear; evidence for a chronic proximal lateral collateral ligament sprain without disruption, and a marginal tear within the posterior horn of the lateral meniscus and degenerative changes within the posterior horn of the medial meniscus. The provider has documented a weak end point to anterior drawer testing. The requested procedures are assessed as regards ODG criteria as follows: In regard to instability ODG requires specifically a positive Lachman sign or a positive pivot shift test, which have not been documented. She would meet the imaging requirements. In regard to meniscectomy, the subjective criteria have been met but not the objective criteria which require at lest tow of the following: a positive McMurray's sign, joint line tenderness, effusion, limited ROM or crepitus. MRI findings are positive for a meniscal tear. In regard to chondroplasty, the subjective findings and conservative treatment meet guideline criteria. However, the clinical notes do not document objective signs of effusion, crepitus or limited ROM. Additionally there is no evidence on imaging of a chondral defect, only a chondromalacia. Although the patient may benefit from revision ACL reconstruction, surgery for meniscectomy and chondroplasty is not indicated based on these reasons.
On March 12, 2010 the patient's medical provider indicated treatment needs as bracing, medication, and Synvisc injections. The patient's attorney subsequently requested preauthorization for Synvisc injections on March 16, 2010.
Request was made for an IRO.

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

ODG criteria for ACL reconstruction include, treatment of PT or bracing plus clinical findings of instability of the knee, described as "buckling or give way" or significant effusion at the time of injury or description of injury indicates rotary twisting or hyperextension incident. There should be a positive Lachman's sign or positive pivot shift or (optional) positive KT 1000 (>3-5 mm = +1, >5-7 mm = + 2, >7 mm = +3). There are should be imaging findings (Not required if acute effusion, hemarthrosis, and instability; or documented history of effusion, hemarthrosis, and instability.) for ACL disruption on MRI or arthroscopy.
ODG criteria for meniscectomy include, (Suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positive): 1. Conservative Care: (Not required for locked/blocked knee.) of PT or medication or activity modification. There should also be clinical findings (at least two): Joint pain or swelling or a feeling of give way or locking, clicking, or popping. There should also be at least two of the following objective clinical findings: Positive McMurray's sign, joint line tenderness, effusion, limited range of motion, locking, clicking, or popping or crepitus. There should also be meniscal tear per MRI.
ODG criteria for chondroplasty require ALL of the following: 1. Conservative Care: Medication or PT plus clinical findings of joint pain and swelling plus, effusion or crepitus or limited range of motion. There should also be imaging findings of a chondral defect on MRI.
Following ACL reconstruction, the patient was hooking up a mud hose to a mud truck and twisted her knee. She used a knee brace and attended PT. MRI of 2008 revealed reinjury to the ACL graft with a possible partial tear. In Janaury 2009 a medial plica was excised and a partial anterior ligament tear debrided. The patient attended therapy and reduced her smoking. Her knee pain continued with popping and shifting. In October 2009 she attended three sessions of PT but stopped as her knee was buckling with therapy. CT scan showed small joint effusion. Exam of October 26, 2009 showed weak endpoint to anterior drawer test. Additional PT has been requested but not authorized. On October 28, 2009 generalized swelling and restricted range of motion are noted. On November 11, 2009 she reported her left knee gave way when she stepped off a curb. Crepitus and instability were noted. She fell several days earlier and still has some swelling. Synvisc injections were requested but do not appear to have been authorized. Updated MRI of January 4, 2010 showed findings suggesting near complete to complete ACL tear, a marginal tear within the posterior horn of the lateral meniscus with degenerative changes within the posterior horn of the medial meniscus. It was noted that abnormal recent arthrogram suggests ACL re-tear. On February 5, 2010 the patient's provider notes generalized tenderness, crepitus and an unstable knee joint. While the need for a 2-day length of stay is unclear, the patient does sufficiently meet the criteria for the requested surgery. Additional conservative treatment options have not been authorized. The patient has been disabled due her knee condition since the prior surgery of over a year prior and is at risk for further injury due buckling and falling and a third surgery does appear medically indicated.
Therefore, recommendation is to disagree with the previous non-certification for right knee revision of ACL reconstruction partial meniscectomy medial lateral synovectomy; chondroplasty; patellar tendon autograft with 2 day LOS
The IRO's decision is consistent with the following guidelines:

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

__X___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

The Official Disability Guidelines (3-26-2010) - Knee and Leg Chapter : ACL Reconstruction:
ODG Indications for Surgeryä -- Anterior cruciate ligament (ACL) reconstruction:
1. Conservative Care: (This step not required for acute injury with hemarthrosis.) Physical therapy. OR Brace. PLUS
2. Subjective Clinical Findings: Pain alone is not an indication for surgery. Instability of the knee, described as "buckling or give way". OR Significant effusion at the time of injury. OR Description of injury indicates rotary twisting or hyperextension incident. PLUS
3. Objective Clinical Findings (in order of preference): Positive Lachman's sign. OR Positive pivot shift. OR (optional) Positive KT 1000 (>3-5 mm = +1, >5-7 mm = + 2, >7 mm = +3). PLUS
4. Imaging Clinical Findings: (Not required if acute effusion, hemarthrosis, and instability; or documented history of effusion, hemarthrosis, and instability.) Required for ACL disruption on: Magnetic resonance imaging (MRI). OR Arthroscopy OR Arthrogram.

The Official Disability Guidelines (3-26-2010) - Knee and Leg Chapter: Meniscectomy:
ODG Indications for Surgeryä -- Meniscectomy:
Criteria for meniscectomy or meniscus repair (Suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positve):
1. Conservative Care: (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. PLUS
2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS
3. Objective Clinical Findings (at least two): Positive McMurray's sign. OR Joint line tenderness. OR Effusion. OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS
4. Imaging Clinical Findings: (Not required for locked/blocked knee.) Meniscal tear on MRI.

The Official Disability Guidelines (3-26-2010) - Knee and Leg Chapter: Chondroplasty:
Recommended as indicated below. Not recommended as a primary treatment for osteoarthritis, since arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical therapy and medical treatment. (Kirkley, 2008) See also Meniscectomy.
ODG Indications for Surgeryä -- Chondroplasty:
Criteria for chondroplasty (shaving or debridement of an articular surface), requiring ALL of the following:
1. Conservative Care: Medication. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Joint pain. AND Swelling. PLUS
3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS
4. Imaging Clinical Findings: Chondral defect on MRI