



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE OF REVIEW: 10/4/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of anterior cruciates ligament reconstruction with tibialis anterior graft (29888, 20924).

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 15 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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of anterior cruciates ligament reconstruction with tibialis anterior graft (29888, 20924).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: Follow-up Notes – 5/13/10-9/2/10, Discharge Summary – 3/12/10, Operative Report – 3/12/10; MD MRI report – 6/30/10; DWC24 – 4/2/09; MD MRI report – 2/7/08; MD Post-op report – 4/1/10, Follow-up Note – 1/7/10-2/4/10, Comprehensive Consultation report – 10/1/09.

Records reviewed from Healthcare: Denial Letters – 7/16/10 & 8/19/10; Denial report – undated; Practice Assoc. Pre-auth request – 7/12/10 & 8/11/10; DC Follow-up note – 6/3/10; and Notice of Disputed Issue/Refusal to Pay Benefits – 7/15/10 & 8/12/10.

Records reviewed from: DC Office Note – 4/21/10 & 7/13/10; MD RME – 6/14/10; and DWC73.

Records reviewed from: MD Follow-up Report – 9/16/10, Evaluation Report – 9/3/10, and Operative Report – 9/3/10.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female. She injured her left knee on xx/xx/xx in a twisting injury. The patient continued working 2 ½ months. An MRI revealed pre-existing moderate arthritis and a torn ACL. An arthroscopy was performed in 3/2010. Instability of knee and no quad atrophy was noted at IME on 6/2010.

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

The patient has documented failure of conservative therapy, history of instability of the knee and instability on independent exam. According to the ODG, the requested services is medically necessary.

ODG Indications for Surgery -- 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).

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)