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Notice of Independent Review Decision

DATE OF REVIEW: 11/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of arthroscopically aided anterior cruciates ligament repair / augmentation or reconstruction.

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 field.

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 arthroscopically aided anterior cruciates ligament repair / augmentation or reconstruction.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: MD Telephone notes – 8/4/10-11/8/10, Office Notes – 6/2/10-10/15/10, Radiographic Study – 6/2/10, Diagnostic Ultrasound – 6/2/10; and CMT and ROM reports – 9/8/10-10/15/10.

Records reviewed from Group: Denial Letters – 10/25/10 & 11/5/10; MRloA review reports – 10/25/10 & 11/8/10; Hospital patient/surgery information sheet –

undated; MRI reports – 2/17/10 & 8/31/10, CT report – 6/16/10(x2); Peer Review Report – 8/4/10; DWC69 – 8/26/10; DWC73; and, MD DDE report – 8/26/10.

Records reviewed from the patient: MD Progress Note – 9/1/10.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant's history involved a fall from a height with a direct trauma to the right knee. The claimant is 10 years status post left knee replacement and has been noted to work as an xx. On xx/xx/xx, the claimant's right knee motion was noted to be from -5-20 degrees of flexion. That and prior AP progress notes reflected a similar (near identical) exam that also revealed joint line tenderness and a lack of effusion. Instability was not documented. A 2/16/10 dated MRI has revealed a partial ACL tear and AVN of the right femoral head and shaft, including large infarcts of the femoral condyles, along with arthrosis and chondromalacia. A 6/16/10 dated CT scan reported AVN within the distal 13 cm. of the femoral shaft. On 8/25/10, the Designated Doctor Exam revealed pain symptoms and only 5 degrees of knee flexion accompanied by "tonic clonic shaking of the leg." Decreased sensation in the L4-5 distribution was also noted. An 8/31/10 dated lumbar MRI revealed an L4-5 protrusion. A 9/1/10 dated 2nd opinion exam revealed that the knee was stable to stress. Denial letters were reviewed.

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

The claimant's subjective complaints are highly associated with pain and do not include mechanical giving way of the knee. In addition, objective findings have not documented clinical instability. MRI findings have not evidenced a full thickness tear of the ACL. Avascular necrosis has been documented within the region of the proposed surgical intervention, and, could be potentially exacerbated by the proposed surgical procedures. Finally, the claimant has evidence of severe arthrofibrosis of the knee which would have a high probability of being further aggravated by the proposed surgical procedures. In this xx year-old with documented osteoarthrosis of the affected knee, marked stiffness and lack of instability, an arthroscopically-assisted ACL reconstruction or repair is not reasonably required as per applicable ODG guidelines.

Reference: ODG-Knee Chapter: ODG Indications for SurgeryTM -- 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.

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)