

US Decisions Inc.

An Independent Review Organization
2629 Goldfinch Dr
Cedar Park, TX 78613-5114
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Anterior Cruciate Ligament (ACL) Reconstruction of the Left Knee with Allograft

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Peer review, Dr. 11/25/09

Peer review, Dr. 12/04/09

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Knee

Office notes, Dr. 07/30/09, 10/16/09, 11/20/09, 01/08/10

Office note, Dr., 08/24/09

PT order, 09/02/09

MRI left knee, 10/27/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is female with a left knee injury on xx/xx/xx when she slipped, fell, and twisted her knee. Dr. noted on 07/30/09 that an MRI showed a medial bucket handle tear. Left knee arthroscopy was done on 08/05/09 that apparently consisted of debridement of medial meniscus tear and the anterior cruciate ligament. Post op physical therapy was ordered. The claimant also treated with Dr. physical medicine and rehab. On 08/24/09 the claimant had left knee effusion and Dr. aspirated 35 cc of clear yellow fluid and cortisone injection was given. Records indicate that additional therapy was ordered on 09/02/09. The claimant continued to have left knee effusion and pain. Treatment consisted of physical therapy, NSAIDs, rest, ice, compression, and elevation. MRI of the left knee on 10/27/09 showed a complete tear of the ACL which was seen laying over the top of the tibial spines, tendinosis to the patellar tendon as it inserts onto the inferior pole of the patella, small amount of fluid in the infrapatellar bursa, tear involving the body of the medial meniscus that extended to it

superior surface. There was also some fraying of the posterior horn of the medial meniscus. There was a contusion involving the medial tibial plateau, grade I strain of the medial collateral ligament and knee effusion. On 11/20/09 Dr. noted increased pain and swelling with symptoms of instability of the knee. On exam there was positive Lachman, positive anterior drawer, and positive pivot shift. The physician recommended arthroscopic ACL reconstruction. The surgery was denied on peer review. On 01/08/10 Dr. noted significant pain and disability as a result of her torn ACL. He noted that the claimant had developed increasing instability of the knee including buckling. She continued to have pain, effusion, instability. He again recommended ACL reconstruction.

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

The records document that the patient has Anterior Cruciate deficiency. This has been documented arthroscopically and by recent MRI. Dr. notes of 11/09 document not only pain and swelling but also symptoms of instability. A positive Lachman and positive pivot shift were documented. The patient has failed prior physical therapy efforts. Dr. most recent note of 01/08/10 clearly outlines pain and disability that he describes to be ACL. He supports this relationship by outlining complaints of knee buckling and ongoing effusion and instability findings. Over time conservative care in this case has included the arthroscopic debridement and therapy as well as activity modification. Subjective findings do include subjective instability complaints as well as the presence of effusions. Objective findings include a positive Lachman and a positive pivot shift from an imaging standpoint the ACL disruption has been confirmed not only by MRI but also by arthroscopy. The ODG indications for ACL reconstruction are met in this case. Based on the ODG and the medical records, the reviewer finds that medical necessity exists for 1 Anterior Cruciate Ligament (ACL) Reconstruction of the Left Knee with Allograft.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Knee

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). 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-AMERICA 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)