P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211
Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 07/14/2010

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 Doctor, 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 arthroscopic debridement 29877 and removal of implant 20680

REVIEW OUTCOME

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

(Overturn) (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.

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PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male who sustained an injury to the right knee on xxxx when he slipped on a wet floor and twisted his knee. He is status post right knee arthroscopy with ACL reconstruction, excision of medial shelf plica, and lateral release on xxxx He was subsequently treated inpatient for post-operative deep vein thrombosis. He initiated PT on xxxx.

Right knee MRI performed xxx was given impression: 1. Mild sprain of the medial collateral ligament. No meniscal tears. 2. Possible tendinopathy of the patellar tendon. 3. Age of injury indeterminate. The patient fell six days prior and continues to have joint pain and difficulty walking.

The patient was examined orthopedically onxxxx. He is on crutches and unable to work. His weight is 350 pounds (height not stated). Knee ROM is 5-90 degrees. There is 1-1+ effusion. There is no laxity. There is pain over the medial joint line. Sensation and motor strength are normal. X-rays show no bony abnormalities, no fractures, subluxation or malalignments. MRI shows some inflammation and partial tearing of the MCL. He will do some PT. He likely has a torn ACL. He is obviously unstable.

The patient underwent arthroscopy on June 11, 2009.

He was seen on June 22, 2010 post-op. Suture and staples were removed. His brace was unlocked. He is under DVT management. He will be started on PT.

He was seen post-op on July 20, 2009. He had some post-op difficulty with deep vein thrombosis and questionable pulmonary embolism. He was admitted post-op and started on anticoagulation. He has been in PT and continues to sue crutches. His knee is very stable. He can discontinue the hinged brace. He can start wearing the shorter wrap around brace. He needs to get on with PT.

PT progress report dated July 28, 2009 notes pain has been decreased from 9/10 to 0-3/10. ROM has been improved from -17 to 30 degrees to 10-110 degrees. Swelling was moderate and is currently +3. He has been doing some HEP, but how much is not clear. HEP will be modified/increased.

Radiographs taken August 17, 2009 show anticipated post-op changes. At this time he is using a cane. He fell two weeks prior. He has a limp. There is trace effusion. The knee is stable. He was advised to do more work hardening in therapy.

PT progress notes of August 27, 2010 note a pain level of 0-2/10 non-weightbearing and occasionally shooting pain of 4/10 with weightbearing. Active ROM is 0 - 102 degrees. Strength is grossly 4+/5. Swelling is +1. He is independent with HEP.

The patient returned to his provider on September 21, 2009. He has been very slow to progress in PT. He describes knee stiffness and a burning type pain in the lower leg. His problems arise from his back, which is being managed by another provider. He does have pain with straight leg raise. As far as his knee, he has excellent ROM although he complains of pain during the examination. He can do limited duty work. He will continue PT with work hardening and knee rehab. He should have his back checked by his treating physician. He does not require a brace any longer.

On November 9, 2009 the provider noted continuing low back complaints being addressed by the patient's primary physician. As far as his knee problem, it has been resolved and he will be dismissed. There is no need for further follow-up for the knee unless he develops problems in the future.

Right knee MRI performed January 27, 2010 and given impression: 1. Post-operative changes compatible with ACL repair is seen. There is extensive altered signal adjacent to the ACL and PCL in the intercondylar notch. The finding is suspicious for granulation tissue or fibrosis. Correlation with clinical scenario is suggested. 2. No recurrent meniscal tears are identified. 3. Age of injury is indeterminate.

Designated Doctor Evaluation was performed on February 15, 2010. No medical records were available for review. He is a machine operator. His past history is significant for heart problems and migraine headaches. He slipped and came down directly on his right knee. He rates his average pain as 7/10. He is 6' 4" and 345 pounds. There is slight swelling. There is no medial or lateral joint line tenderness. There is normal patellar tracking without crepitus. Ligaments are intact and McMurray's is negative. He was unable to perform the jerk test (pivot shift). Right knee extension is to 4 degrees and flexion to 55 degrees. He should be MMI about May 15, 2010. He is still symptomatic and should follow up with his orthopedic provider.

Radiographs taken April 23, 2010 show tibiofemoral joint is maintained. Post surgical changes are seen consistent with ligament repair. Mild spurring is seen superiorly from the patella. No other findings.

Reevaluation of May 6, 2010 noted healed ACL reconstruction with a stable knee but significant decreased motion and fibrosis with associated pain. He also has persisting low back pain that radiates. Repeat MRI showed some hypertrophic granulation tissue in the intercondylar notch consistent with a Cyclops lesion and this may be associated with some of his decreased ROM and possibly even some of his pain. "While I think the Cyclops lesion is contributing to his pain, I still have some doubts insofar as that being the complete etiology of his discomfort." We will set him up for arthroscopic debridement to remove the granulation tissue followed by aggressive PT. The painful hardware should also be removed at the same sitting.

Request for right knee arthroscopic debridement and removal of implant was considered in review on May 24, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. The patient underwent arthroscopy on June 11, 2009 with ACL reconstruction, excision of medial shelf plica, and lateral release on June 11, 2009. He was subsequently treated inpatient for post-operative deep vein thrombosis. He initiated PT on June 24, 2009. On August 27, 2009 he reported pain of 2/10 and demonstrated motion of 0-102 degrees and strength of 4+/5. On January 12, 2010 he complained of persistent severe pain and swelling of the right knee. Effusion was noted as 2+. MRI of January 27, 2010 noted suspicion for granulation tissue or fibrosis in the intercondylar notch, adjacent to the ACL and PCL. Designated Doctor opinion of February 14, 2010 opined the patient is not at MMI due limited motion and pain. The clinical note of May 7, 2010 reported decreased motion and fibrosis with associated pain and motion of 5-90 degrees of motion. Surgery was recommended. Rationale for denial notes evidence of granulation tissue or fibrosis in the intercondylar notch adjacent to the ACL. The patient is noted to have persistent pain and limited ROM by post-operative treatment. There is no indication that the patient's hardware site is the pain generator. ODG does not recommend the routine removal of hardware, unless other pain generators have been ruled out, or there is evidence of hardware failure.

Request for reconsideration right knee arthroscopic debridement and removal of implant was considered in review on June 8, 2010 with recommendation for non-certification. Nurse notes indicate a second Designated Doctor exam was set for April 26, 2010; however, this report is not available. Reports indicate the patient was at a sedentary status post-operatively. There is a history of post-op DVT and possible pulmonary embolism. The knee is very stable but painful and with limited motion and fibrosis. ROM is 5-90 degrees. Denies numbness and tingling. "At his request we are going to set him up for debridement of hypertrophic granulation tissue in the intercondylar notch followed by aggressive PT." No PT or work conditioning notes were submitted with this referral. Notes of August 17, 2009 note full ROM, negative Lachman and negative pivot shift, trace effusion. Post DVT and pneumonia. Recommending increased work hardening in PT. September 21, 2009 note mentions new body part and return for final follow up for the knee with anticipation for MMI. A peer discussion was attempted but not realized. Rationale for denial notes lack of an operative report. MRI showed suspicion for granulation tissue fibrosis and no recurrent meniscal tears. There is no documentation of exhaustion of conservative treatment; the pain medications were not reported. No documentation presented of tests and maneuvers done indicating the knee pathology. Also, he has a very stable knee. Routine removal of hardware is not supported without ruling out other causes of pain such as infection and nonunion. The maximum potential of the conservative treatment done was not fully exhausted to indicate a surgical procedure.

Request was made for an IRO.

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

Per ODG, second look arthroscopy is only recommended in case of complications from OATS or ACI procedures, to assess how the repair is healing, or in individual cases that are ethically defendable for scientific reasons, only after a thorough and full informed consent procedure. Criteria for diagnostic arthroscopy: 1. Conservative Care: Medications. OR Physical therapy. PLUS 2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS 3. Imaging Clinical Findings: Imaging is inconclusive.

Hardware Implant Removal: Not recommend the routine removal of hardware implanted for fracture fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection. Although hardware removal is commonly done, it should not be considered a routine procedure. For more information & references, see the Ankle Chapter.

The patient is approximately 13 months post right knee arthroscopy with ACL reconstruction, excision of medial shelf plica, and lateral release. The patient is 350 pounds and was sedentary after the surgery and had some post-op difficulty with deep vein thrombosis and questionable pulmonary embolism. He attended PT and by August 27, 2010 had active ROM is 0 - 102 degrees, gross strength of 4+/5 and 1+ swelling. He was independent with HEP. In September 2009 he no longer needs a brace. His back was an issue and is being treated by another provider. On November 9, 2009 his knee problem has been resolved and he will be dismissed as there is no need for further follow-up for the knee unless he develops problems in the future. Updated MRI of January 2010 showed post-operative changes compatible with ACL repair and extensive altered signal adjacent to the ACL and PCL in the intercondylar notch which is suspicious for granulation tissue or fibrosis. Per DD exam of February 2010, there is slight swelling. There is no medial or lateral joint line tenderness. There is normal patellar tracking without crepitus. Ligaments are intact and McMurray's is negative. He was unable to perform the jerk test (pivot shift). Right knee extension is to 4 degrees and flexion to 55 degrees. He should be MMI about May 15, 2010. He is still symptomatic and should follow up with his orthopedic provider. On May 6, 2010 his provider noted, "While I think the Cyclops lesion is contributing to his pain, I still have some doubts insofar as that being the complete etiology of his discomfort." We will set him up for arthroscopic debridement to remove the granulation tissue followed by aggressive PT. The painful hardware should also be removed at the same sitting.

First-line review rationale for denial notes evidence of granulation tissue or fibrosis in the intercondylar notch adjacent to the ACL. The patient is noted to have persistent pain and limited ROM by post-operative treatment. There is no indication that the patient's hardware site is the pain generator. ODG does not recommend the routine removal of hardware, unless other pain generators have been ruled out, or there is evidence of hardware failure

Second-line review rationale for denial notes lack of an operative report. MRI showed suspicion for granulation tissue fibrosis and no recurrent meniscal tears. There is no documentation of exhaustion of conservative treatment; the pain medications were not reported. No documentation presented of tests and maneuvers done indicating the knee pathology. Also, he has a very stable knee. Routine removal of hardware is not supported without ruling out other causes of pain such as infection and nonunion. The maximum potential of the conservative treatment done was not fully exhausted to indicate a surgical procedure.

There is doubt regarding the pain generator. Per the DD exam, there is slight swelling. There is no medial or lateral joint line tenderness. There is normal patellar tracking without crepitus. Ligaments are intact and McMurray's is negative. He was unable to perform the jerk test (pivot shift). The patient has a stable knee with no evidence of hardware failure. However, he has limited motion and persisting pain. He needs debridement to remove the granulation tissue and hardware removal is part of the procedure if it is found to be impinging at the time of surgery. .

Therefore, my recommendation is to disagree the previous non-certification of the request for right knee arthroscopic debridement 29877 and removal of implant 20680.
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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 06-30-2010 Knee and Leg Chapter: Diagnostic Arthroscopy:

Recommended as indicated below. Second look arthroscopy is only recommended in case of complications from OATS or ACI procedures, to assess how the repair is healing, or in individual cases that are ethically defendable for scientific reasons, only after a thorough and full informed consent procedure. In patients with osteoarthritis, the value of MRI for a precise grading of the cartilage is limited, compared to diagnostic arthroplasty. When the assessment of the cartilage is crucial for a definitive decision regarding therapeutic options in patients with osteoarthritis, arthroscopy should not be generally replaced by MRI. The diagnostic values of MRI grading, using arthroscopy as reference standard, were calculated for each grade of cartilage damage. For grade 1, 2 and 3 lesions, sensitivities were relatively poor, whereas relatively better values were noted for grade 4 disorders.
ODG Indications for Surgeryä -- Diagnostic arthroscopy:
Criteria for diagnostic arthroscopy:
1. Conservative Care: Medications. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS
3. Imaging Clinical Findings: Imaging is inconclusive.

Hardware Implant Removal: Not recommend the routine removal of hardware implanted for fracture fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection. Although hardware removal is commonly done, it should not be considered a routine procedure. For more information & references, see the Ankle Chapter.