



Notice of Independent Review Decision

DATE OF REVIEW:

09/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right knee EUA arthroscopy, anterior cruciate ligament substitution with allograft tibial tendon using the femoral over the top button and either post fixation of soft tissue screw fixation in the tibial lateral/medical meniscectomy extensive debridement removal.

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The requested procedure (right knee EUA arthroscopy, anterior cruciate substitution with allograft tibial tendon using the femoral over the top button and either post fixation of soft tissue screw fixation in the tibia, lateral/medial meniscectomy, with extensive debridement/removal) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 08/26/10 Fax Cover sheet with note from, I-Resolutions
- 08/25/10 MCMC Referral
- 08/24/10 Notice to MCMC, LLC of Case Assignment, , DWC
- 08/16/10 Confirmation Of Receipt Of A Request For A Review, DWC
- 08/16/10 Notice to Utilization Review Agent of Assignment, , DWC
- 08/13/10 Request For A Review By An Independent Review Organization
- 07/23/10 request for services letter from M.D.,
- 07/15/10 Request for Reconsideration of Preauthorization letter, , M.D.
- 07/01/10 Notification of Determination letter, , M.D.,
- 06/28/10 Pre-Authorization Request Form,
- 06/17/10 report from, M.D.
- 05/13/10 MRI right knee,
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a male who was reported to have sustained a work-related injury on xx/xx/xx. There is no information regarding the details of the mechanism of injury or subsequent treatment

except that the injured individual had undergone anterior cruciate ligament (ACL) reconstruction with a bone–patellar tendon-bone graft in 1997. No details regarding how he did following the initial surgery are available for review. The only medical is an evaluation performed by M.D. on 06/17/2010. Based on documentation he only saw the injured individual one time and recommended the requested procedure. His examination documented at least 25 % quadriceps atrophy, positive medial and lateral McMurray’s signs, and ligament testing consistent with an ACL deficient knee. The MRI performed on 05/13/2010 revealed evidence of disruption of the previous ACL graft, prior partial medial meniscectomy, possible complex tear of the lateral meniscus, cartilage thinning and moderate osteoarthritic changes of all three compartments. In addition, there was a question of filling defects consistent with loose bodies or villonodular synovitis and enlargement of the graft tunnels in both the femur and tibia. There is no other evidence of documented treatment in the material available for review.

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

The injured individual is a male who had previously undergone ACL reconstructive surgery in 1997 following an unknown work-related injury. There is no information of how the injured individual did following that procedure. It is unclear whether the injured individual has had another injury or has had progressive worsening of his knee condition. Dr. documented significant quadriceps atrophy without addressing it. The MRI revealed tricompartmental degenerative changes with evidence of prior medial meniscectomy, complex degenerative tearing of the lateral meniscus and ACL graft disruption. Enlargement and endosteal erosion of the femoral and tibial graft tunnels were identified but not addressed in the surgical plan.

ACL reconstruction is not typically recommended in the setting of advance degenerative disease. This injured individual appears to have significant degenerative changes as documented in the MRI report. There has been no attempt to improve his significant quadriceps atrophy. The MRI reported significant patellofemoral issues which have not been addressed by the requesting physician and is a major complicating factor. Graft tunnel enlargement has not been addressed or a treatment plan outlined. The requested procedure does not meet the Official Disability Guidelines criteria.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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. (Washington, 2003) (Woo, 2000) (Shelbourne, 2000) (Millett, 2004)

Recommended as indicated below. An examination of all studies that compared operative and conservative treatment of anterior cruciate ligament (ACL) rupture found that outcomes in the operative groups were generally better than in the conservative groups for younger patients, but outcomes are worse in older patients (age beyond 50-60 years). (Hinterwimmer, 2003) (Linko-Cochrane, 2005) Morbidity is lower for hamstring autografts than for patellar tendon autografts used for ACL reconstruction. (Biau, 2006) The use of bracing after anterior cruciate ligament (ACL) reconstruction cannot be rationalized by evidence of improved outcome including measurements of pain, range of motion, graft stability, or protection from injury. (Wright, 2007) Most of the roughly 100,000 ACL reconstructions performed each year are for younger patients. Although age has been considered a relative contraindication for ACL surgery in the past, active older patients may respond well to this surgery and should not be ruled out as surgical candidates based solely on their age. It is important to look at their comorbidities, e.g., malalignment and osteoarthritis, because they predict potential problems. (Wulf, 2008) Anterior cruciate ligament (ACL) reconstruction using an allograft has a high failure rate in young, active adults. While there are obvious benefits of using the cadaver ligament, like avoiding a second surgical site on the patient, a quicker return to work and less postoperative pain, for the young patient who is very active, it may not be the right choice. (Luber, 2008) In patients with ACL injury willing to moderate activity level to avoid reinjury, initial treatment without ACL reconstruction should be considered. All ACL-injured patients need to begin knee-specialized physical therapy early (within a week) after the ACL injury to learn more about the injury, to lower the activity level while performing neuromuscular training to restore the functional stability, and as far as possible avoid further giving-way or re-injuries in the same or the other knee, irrespectively if ACL is reconstructed or not. (Neuman, 2008) Patients with anterior cruciate ligament (ACL) injuries may not need surgery. At 2-5 years after injury, muscle strength and function were similar in patients treated with physical therapy and surgical reconstruction or physical therapy only. ACL injuries are associated with the development of osteoarthritis (OA) in the long term, and there is no evidence to suggest that reconstruction of the ACL prevents or reduces the rate of early-onset OA. On the contrary, the prevalence of OA may be even higher in patients with reconstructed ACL than in those with nonreconstructed ACL. (Ageberg, 2008) Immediate surgical reconstruction may not be needed for ACL tears, according to the results of an RCT in the New England Journal of Medicine. Some patients who are not elite athletes can function with an ACL-deficient knee, but it is difficult to predict which patients will have symptoms of instability that require surgery. (Frobell, 2010)

ODG Indications for Surgery:-- 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 positive):

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. (Washington, 2003)

Recommended as indicated below for symptomatic meniscal tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings. (Kirkley, 2008) Meniscectomy is a surgical procedure associated with a high risk of knee osteoarthritis (OA). One study concludes that the long-term outcome of meniscal injury and surgery appears to be determined largely by the type of meniscal tear, and that a partial meniscectomy may have better long-term results than a subtotal meniscectomy for a degenerative tear. (Englund, 2001) Another study concludes that partial meniscectomy may allow a slightly enhanced recovery rate as well as a potentially improved overall functional outcome including better knee stability in the long term compared with total meniscectomy. (Howell-Cochrane, 2002) The following characteristics were associated with a surgeon's judgment that a patient would likely benefit from knee surgery: a history of sports-related trauma, low functional status, limited knee flexion or extension, medial or lateral knee joint line tenderness, a click or pain noted with the McMurray test, and a positive Lachmann or anterior drawer test. (Solomon, 2004) Our conclusion is that operative treatment with complete repair of all torn structures produces the best overall knee function with better knee stability and patient satisfaction. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery will not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis, and meniscectomy will not improve the OA. Meniscal repair is much more complicated than meniscal excision (meniscectomy). Some surgeons state in an operative report that they performed a meniscal repair when they may really mean a meniscectomy. A meniscus repair is a surgical procedure done to repair the damaged meniscus. This procedure can restore the normal anatomy of the knee, and has a better long-term prognosis when successful. However, the meniscus repair is a more significant surgery, the recovery is longer, and, because of limited blood supply to the meniscus, it is not always possible. A meniscectomy is a procedure to remove the torn portion of the meniscus. This procedure is far more commonly performed than a meniscus repair. Most meniscus tears cannot be treated by a repair. See also Meniscal allograft transplantation. (Harner, 2004) (Graf, 2004) (Wong, 2004) (Solomon-JAMA, 2001) (Chatain, 2003) (Chatain-Robinson, 2001) (Englund, 2004) (Englund, 2003) (Menetrey, 2002) (Pearse, 2003) (Roos, 2000) (Roos, 2001) Arthroscopic debridement of meniscus tears and knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for all patients with knee osteoarthritis. (Siparsky, 2007) Arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical and medical therapy, according to the results of a single-center, RCT reported in the New England Journal of Medicine. The study, combined with other evidence, indicates that osteoarthritis of the knee (in the absence of a history and physical examination suggesting meniscal or other findings) is not an indication for arthroscopic surgery and indeed has been associated with inferior outcomes after arthroscopic knee surgery. However, osteoarthritis is not a contraindication to arthroscopic surgery, and arthroscopic surgery remains appropriate in patients with arthritis in specific situations in which osteoarthritis is not believed to be the primary cause of pain. (Kirkley, 2008) Asymptomatic meniscal tears are common in older adults, based on studying MRI scans of the right knee of 991 randomly selected, ambulatory subjects. Incidental meniscal findings on MRI of the knee are common in the general population and increase with increasing age. Identifying a tear in a person with knee pain does not mean that the tear is the cause of the pain. (Englund, 2008) Arthroscopic meniscal repair results in good clinical and anatomic outcomes. (Pujol, 2008) Whether or not meniscal surgery is performed, meniscal tears in the knee increase the risk of developing osteoarthritis in middle age and elderly patients, and individuals with meniscal tear were 5.7 times more likely to develop knee osteoarthritis. (Englund, 2009)