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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Out Patient Lt Knee Patellar Disloc/Recon VMO 27422 and DME Patellar Stabilizing Sleeve

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)
[X] Partially Overturned (Agree in part/Disagree in part)

The reviewer finds there is not medical necessity at this time for Out Patient Lt Knee Patellar Disloc/Recon VMO 27422. The reviewer finds there is a medical necessity for DME Patellar Stabilizing Sleeve.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates Knee and Leg Chapter – Does not address the specific surgery, only the Knee Brace
ER Discharge Record: 04/08/11
04/14/11, 04/18/11
PT Records: 04/15/11,
Patient Information Forms Orthopedics: 04/19/11
Orthopedics Dr. MD: 04/20/11, 05/02/11, 06/29/11
MRI Report Left Knee: 04/20/11
PT Script Dr.: 05/02/11
Peer Review Dr. MD, Ortho: 07/08/11
Peer Review Dr. MD Ortho: 07/15/11

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a female employed as a. The claimant sustained a work related injury to her left knee on xx/xx/xx while. The claimant moved to the right and her left knee went out to the left. The claimant grabbed her knee and put it back into place experiencing extreme pain and swelling. The claimant was taken to the emergency room and treated conservatively with oral pain and anti-inflammatory medications, a knee immobilizer and crutches. Conservative treatment was continued by occupational medicine with the addition of limited physical therapy. The therapist noted on 04/15/11 that the claimant's job description stated that the physical demand was walking and standing most of the time. On 04/18/11 the claimant stated she was not working due to her employer's inability to accommodate her restrictions.

On 04/20/11 the claimant was evaluated by orthopedics, Dr., for continued left knee pain. Exam findings revealed full extension and flexion to 80 degrees. There was a ten-milliliter (10 ml) palpable effusion and possible hemiarthrosis. Motor and sensory testing were intact. There was tenderness to palpation at the medial joint line, none in lateral joint line. There was pain with any type of patella manipulation. The left knee was ligamentously stable at varus and valgus stressing. Any secondary maneuvers were unable to be done secondary to lack of range of motion. Dr. noted that a review of x-rays done in the emergency room was not done due to an inability to pull them up through the system, however, per patient report they were negative. Dr. assessment was left knee pain with effusion and a questionable patellar dislocation. An MRI of the knee was ordered.

The MRI was done on 04/20/11 and demonstrated the following: the anterior and posterior cruciate ligaments (ACL and PCL) were normal. Lateral and medial menisci were normal, as were the collateral ligaments. Extensor mechanism: Quadriceps and patellar tendons were intact. There was evidence of recent transient patellar dislocation. The medial patellofemoral ligament and medial patellar retinaculum were torn at the femoral attachment. There was a contusion of the anterolateral aspect of the lateral femoral condyle. A kissing contusion involving the medial or inferomedial aspect of the patella was noted related to the transient patellar dislocation. Cartilage loss at the odd facet of the patella could not be excluded. There was a bone contusion present immediately beneath the odd facet. Otherwise no osteochondral lesion was seen or other cartilage loss was suspected. A moderate sized joint effusion and a small Baker's cyst were noted as well.

The claimant returned to Dr. on 05/02/11 with decreased pain taking only Ibuprofen. The patient was not currently in therapy. Exam finding revealed full extension and flexion to 120 degrees. There was pain with lateral patellar manipulation with good tracking of the patella. The MRI of 04/20/11 was reviewed per report. Dr. ordered formal physical therapy three times per week for six weeks with instruction in a home exercise program (HEP) and the use of a patellar stabilizing brace.

At the 06/29/11 visit the claimant reported that the pain continued to improve. Dr. noted that the claimant presented with a "pretty destroyed knee brace" and the claimant was requesting a replacement. A patellar stabilizing sleeve was ordered by Dr. but denied per insurance. The claimant reported that she was dong her HEP and not taking any medication for pain. Exam revealed full extension and flexion to 115 degrees with ligamentously stability with varus and valgus stressing. Anterior and posterior drawer tests were negative as were Lachman and McMurray. The claimant continued to have increased lateral patellar laxity and apprehension when the knee was flexed at 30 degrees which laterally subluxated the patella. There was not any palpable effusion. Dr. impression was Left patellar dislocation with the continued recommendation for a patellar stabilizing sleeve with continuation of her HEP. Dr. also offered a surgical intervention in the form of a Vastus Medialis Obliquus Advancement. The claimant was to inform Dr. of her decision.

Of note, the request for the surgery and patellar-stabilizing sleeve was denied twice per peer review on 07/08/11 and on 07/15/11.

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

The records indicate this claimant has patellar instability. For such, a patellar sleeve would be appropriate. The claimant would be a candidate for a patella stabilizing sleeve. She has a documented patellar dislocation. Official Disability Guidelines were referenced for knee braces. One of the criteria for such is knee instability, which would then include patellar instability. Reconstruction with VMO advancement was also requested, however; it has not been noted if the claimant wished to proceed with such. A note of 06/29/11 reported pain, but she continued to improve. Based on the limited information, one could not ascertain, however, if she is a candidate for surgery at the present time.

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be Partially Overturned. The reviewer finds there is not medical necessity at this time for Out Patient Lt Knee Patellar Disloc/Recon VMO 27422. The reviewer finds there is a medical necessity for DME Patellar Stabilizing Sleeve.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates Knee and Leg Chapter – Does not address the specific surgery, only the Knee Brace

Knee brace

Recommended as indicated below. There are no high quality studies that support or refute the benefits of knee braces for patellar instability, ACL tear, or MCL instability, but in some patients a knee brace can increase confidence, which may indirectly help with the healing process. In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is going to be stressing the knee under load. (Bengal, 1997) (Crossley, 2001) (D'hondt-Cochrane, 2002) (Miller, 1997) (Yeung-Cochrane, 2002) (Van Tiggelen, 2004) There are no data in the published peer-reviewed literature that shows that custom-fabricated functional knee braces offer any benefit over prefabricated, off-the-shelf braces in terms of activities of daily living. (BlueCross BlueShield, 2004) 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) Among patients with knee OA and mild or moderate valgus or varus instability, a knee brace can reduce pain, improve stability, and reduce the risk of falling. (Zhang, 2008) Patellar taping, and possibly patellar bracing, relieves chronic knee pain, according to a recent meta-analysis. Patellar taping may be preferred over bracing due to the fact that there is much more evidence for taping than bracing, and also because taping produces better clinical results in terms of reductions in pain than patellar bracing, plus patients are more active in their rehabilitation with taping than with bracing. (Warden, 2008) The results of this systematic review suggest that knee braces and foot orthoses are effective in decreasing pain, joint stiffness, and drug dosage, and they also improve proprioception, balance, Kellgren/Lawrence grading, and physical function scores in subjects with varus and valgus knee osteoarthritis. They should be cautiously considered as conservative management for relief of pain and stiffness and improving physical function for persons with knee osteoarthritis. (Raja, 2011)

Criteria for the use of knee braces

Prefabricated knee braces may be appropriate in patients with one of the following conditions

1. Knee instability

2. Ligament insufficiency/deficiency

3. Reconstructed ligament

4. Articular defect repair

5. Avascular necrosis

6. Meniscal cartilage repair

7. Painful failed total knee arthroplasty

8. Painful high tibial osteotomy

9. Painful unicompartmental osteoarthritis

10. Tibial plateau fracture

AAOS, Orthopedic Knowledge Update 9, Fischgrund, Editor. Chapter 62, page 764.

Management of patellofemoral instability is based on the magnitude of instability, frequency of instability, presence of associated injuries and patellofemoral alignment. Surgical treatment of patellofemoral instability includes proximal and distal realignment procedures. Proximally, lateral release, medial plication, vastus medialis advancement, and medial patellofemoral ligament repair or reconstruction may be performed. Distally, tibial tubercle metallization or anteromedialization osteotomy may be performed.

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

[X] 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

[x] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION: AAOS, Orthopedic Knowledge Update 9, Fischgrund, Editor. Chapter 62, page 764.

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)