

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 28, 2011 **Amended October 12, 2011**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Appeal Right Knee Arthroscopy ACL Reconstruction with Achilles Allograft 29888
Appeal and Right Knee Partial Medial Meniscectomy 29888 29881

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

This physician is Board Certified Orthopedic Surgeon with over 40 years of experience.

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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On May 15, 2009, MRI of the right knee.

On June 12, 2009, MD OP Report.

On June 27, 2011, MD office note and x-rays.

On July 6, 2009, PT note.

July 27, 2009, MD, an orthopedic surgeon, office note.

On August 16, 2011, an MRI of the right knee.

On August 17, 2011, M.D. office note.

On August 3, 2011, M.D. performed a utilization review.

On August 25, 2011, M.D performed a utilization.

PATIENT CLINICAL HISTORY:

The claimant is a male.

On xx/xx/xx, an MRI of the right knee was performed. Impression: Extensive bone contusion involving the medial femoral condyle. Mild bone contusion involving the posteromedial proximal tibial plateau. High grade sprain and probable tear of the medial collateral and anterior cruciate ligaments. Horizontal tear of the posterior horn of the medial meniscus as interpreted by, MD.

On June 12, 2009, MD performed surgery of the right knee. Procedures: 1. Examination of the right knee under anesthesia. 2. Right knee arthroscopy. 3. Partial debridement of the posterior horn of the lateral meniscus, and ACL.

On June 27, 2011, Mr. was evaluated by MD. He has complaints of pain to the hip and knee area. X-rays revealed moderate degenerative changes. He was referred to an orthopedic surgeon.

On July 6, 2009, Mr. began physical therapy of the right knee three times a week for 6-8 weeks.

July 27, 2009, Mr. was evaluated by MD, an orthopedic surgeon. He has pain that radiates from the right knee up to the hip area. He describes instability and stiffness. Dr. recommended surgical intervention of the right knee.

On August 16, 2011, an MRI of the right knee was performed. Impression: 1. Grade III chondromalacia patellofemoral joint space, patella alta, and patellar tendinosis with minimal suprapatellar synovitis and deep infrapatellar bursitis. 2. Chronic ACL and almost full thickness tear of the PCL proximally. 3. Significant atrophy with fatty replacement involving the biceps muscle associated with partial tear of the distal biceps tendon and lateral collateral ligament as interpreted by MD.

On August 17, 2011, MR. was re-evaluated by MD. He is continuing to work light duty. Dr. again recommended ACL reconstruction.

On August 3, 2011, M.D., an orthopedist, performed a utilization review on the claimant Rational for Denial: There is no documentation of recent diagnostic imaging study. Therefore, it is not certified.

On August 25, 2011, M.D., an orthopedic surgeon, performed a utilization review on the claimant Rational for Denial: Objective documentation that the claimant has recently received and failed maximal and optimal conservative care (Physical therapy, medications, injections, and activity modification) is not submitted for review. Therefore, it is not certified.

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

The previous decisions are upheld. Per the ODG there has to be documentation of conservative care. Based on the medical records provided for review the claimant has not undergone adequate conservative care in the form of physical therapy. Without documented conservative care surgical intervention is not warranted.

PER THE ODG:

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](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).

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](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).

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)