

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: April 17, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroscopy left knee/ACL reconstruction.

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

M.D., Board Certified in Orthopedic Surgery.

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)

The requested arthroscopy left knee/ACL reconstruction is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 3/28/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 3/29/12.
3. Notice of Assignment of Independent Review Organization dated 3/29/12.
4. Letter dated 3/29/12.
5. Letter dated 4/03/12.
6. ODG Treatment Guidelines.
7. Texas Department of Insurance General Provisions Regarding Independent Review Organizations.
8. Preauthorization request forms dated 2/21/12 through 3/22/12.
9. Medical records dated 2/16/12 through 3/15/12.
10. Medical records MD dated 1/12/12.
11. MRI of the left knee dated 8/17/11.
12. Medical records Medical Centers dated 8/08/11 through 9/26/11.
13. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reportedly fell on xx/xx/xx, resulting in injuries to the left knee and left shoulder. On 1/12/12, the medical records noted that prior MRI of the left knee showed a medial meniscal tear, as well as a partial tear of the anterior cruciate ligament. The patient's diagnoses on this date included left shoulder pain, internal derangement, left knee, cervical strain and thoracic strain. On 2/16/12, the medical records noted that left knee range of motion was limited by pain. The documentation noted diffuse soft tissue swelling. The provider recommended arthroscopic anterior cruciate ligament reconstruction on this date.

The URA indicated that the patient does not meet Official Disability Guidelines (ODG) criteria for the requested procedure. Specifically, the URA's initial denial noted that there is no formal physician documentation, including recent physical examinations, to support this request. On appeal, the URA noted that the patient weighs 245 pounds, and he has arthritic changes on imaging. Per the URA, there is high risk for worsening of the knee condition with anterior cruciate ligament (ACL) reconstruction in this clinical setting.

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

Official Disability Guidelines (ODG) suggest that the requested procedure may be indicated for individuals with an unstable knee, including a positive Lachman's and pivot shift, with imaging studies that support the diagnosis of an ACL tear for whom conservative care has failed. Historically, anterior cruciate ligament tears have a high incidence of leading to progressive

deterioration of the joint. The indications for surgery in most individuals are not only based on the relative instability, but based on their age, comorbidities, and activity level. As individuals age, the literature suggests that there is a much lower incidence of individuals necessitating surgery as opposed to young, more active, individuals. Furthermore, the literature suggests that patients who have chronic conditions with a significant amount of degenerative change are not ideal candidates for surgical intervention. In this patient's case, the MRI scan describes what appears to be a chronic ACL tear as well as significant moderate to severe chondromalacia of the lateral compartment with full thickness defects and mild to moderate degenerative change in the medial compartment. The ODG notes that indications for the requested surgery include conservative care, which includes physical therapy or bracing. In this patient's case, there is no indication to suggest that he has failed a period of bracing for his chronic ACL tear. Additionally, there is no indication to suggest that this patient's ongoing complaints are in fact related to his ACL as opposed to his degenerative changes which appear to be most significant. All told, the requested arthroscopy left knee/ACL reconstruction is not medically necessary for the treatment of this patient.

Therefore, I have determined the requested arthroscopy left knee/ACL reconstruction is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)**