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Notice of Independent Review Decision

DATE OF REVIEW: March 7, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee arthroscopy and/or other procedures as may be found necessary (29870)

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

Fellow American Academy of Orthopaedic Surgeons

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits (08/30/10 – 01/23/12)
- Diagnostics (08/30/10 – 05/02/11)
- Therapy (09/01/10 – 04/07/11)
- Operative report (10/18/10)
- Reviews (05/31/11 – 01/11/12)
- Utilization reviews (07/19/11, 09/20/11)

- Operative report (10/18/10)
- Diagnostics (05/02/11)
- Office visits (08/16/11 – 12/22/11)
- Reviews (05/31/11 – 12/13/11)
- Utilization reviews (07/19/11, 12/28/11, 01/04/12, 01/23/12, 01/24/12, 01/25/12)

- Diagnostics (09/04/10 – 05/02/11)
- Office visits (10/18/11 – 02/22/12)

- Utilization reviews (01/04/12, 01/23/12, 01/25/12)

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who hopped down off a platform on xx/xx/xx. His body weight went one way and knees the other way, resulting in injury to the left knee.

2010: Following the injury, the patient was taken to where he underwent x-rays of the left knee that showed medial soft tissue swelling and increased density in the infrapatellar fat pad suggesting edema. The patient was prescribed ibuprofen and Darvocet N-100.

evaluated the patient for the knee complaints. History was positive for hernia repair, left arm and wrist injury, spinal cord stimulator (SCS) and arthritis. Examination showed the patient was non-weightbearing with crutches and immobilizer to the left knee, swelling and edema located superior and inferior to the patellar region throughout the joint space, positive valgus strain and moderate-to-severe pain of the medial collateral radiating across infrapatellarly. assessed subluxated patella, probable meniscal and medial collateral trauma. He recommended conservative treatment and ordered MRI of the left knee.

From September through October, the patient attended 10 sessions of PT consisting of cold/hot pack, electrical muscle stimulation (EMS) and ultrasound.

MRI of the left knee showed degenerative or posttraumatic changes within the central medial meniscus without evidence of meniscal tear, evidence for linear decreased signal interface within posterior horn of the lateral meniscus suggestive of marginal meniscal tear, edematous changes within the distal anterior cruciate ligament (ACL) and proximal lateral collateral ligament (LCL) and unusual appearance of patella with mixed signal lesion demonstrated in the inferior patella as well as high signal possibly due to bone contusion and decreased signal of the inferior patella possibly representing a subcortical fracture line.

evaluated the patient for bilateral knee pain. Examination showed moderately reduced range of motion (ROM) of the left knee, tenderness at the patella, moderate effusion and pain with valgus stress. assessed LCL sprain and possible tear of the medial collateral ligament (MCL), prescribed Darvocet and Naprosyn and referred the patient to an orthopedic surgeon.

an orthopedic surgeon, evaluated the patient for left knee pain. Review of systems was positive for fatigue, hay fever, abdominal pain, heartburn, rectal bleeding, arthritis, joint pain, stiffness and muscle pain. X-rays of the left knee were unremarkable. assessed lateral meniscus tear, chondromalacia patella and contusion of the knee/lower leg.

On October 18, 2010, performed diagnostic and operative arthroscopy of the left knee with extensive tricompartmental synovectomy and chondroplasty of the patella and distal intertrochlear groove of the femur and medial plica resection.

On follow-up, noted ongoing right knee pain and popping. Examination of the left knee showed moderate effusion and decreased ROM. Examination of the right knee showed crepitance on ROM and positive McMurray's both medial and laterally and tenderness of the joint line bilaterally. assessed status post bilateral knee injury with an unmasking of knee pain as the left knee was improving. He ordered MRI of the right knee to determine the amount of damage done.

2011: In a functional capacity evaluation (FCE) dated January 11, 2011, the patient did not meet his reported job lifting requirement and was recommended work conditioning program (WCP).

In March, noted that the patient had started work conditioning after physical therapy (PT) program. The patient reported that he was very sore from PT and work conditioning program (WCP) and his knee was popping a lot especially on friction. Examination showed tightness on flexion, mild to minimal effusion, tenderness medially in the infrapatellar area with mild tenderness and proximal attachment of LCL and painful McMurray's test. recommended continuing WCP and medications.

noted swelling and increased pain in the left knee. The patient complained of shifting, popping and clicking of the left knee. assessed ACL sprain/strain/tear, knee pain and tear of the meniscus and recommended MRI of the left knee. He opined that the patient would require an ACL reconstruction.

In April, noted that the patient had interrupted sleep and increase pain since starting another work hardening program (WHP). He prescribed Ambien and Prozac and recommended follow-up in two weeks.

A repeat MRI of the left knee showed focal osteochondral lesion at the medial articular surface of the patella and mild joint effusion. reviewed MRI and administered a left knee injection and prescribed tramadol.

On May 31, 2011, performed a designated doctor evaluation (DDE) and opined that the patient had reached maximum medical improvement (MMI) with 4% whole person impairment (WPI) rating. obtained an FCE in which the patient performed inconsistently with a submaximal effort. He opined that the patient should at least be capable of medium PDL.

In June, administered a Synvisc injection and recommended referral for second opinion. On follow-up noted increased pain medially with instability and giving way and swelling. The patient was wearing a brace which was helping. Examination showed antalgic and compensated gait, atrophy of vastus medialis, diffuse tenderness of left knee and medial patellar facet, mild crepitus, positive apprehension, painful active and passive ROM. recommended arthroscopy of the left knee.

According to the letter of Office of Injured Employee Counsel, a written clarification was obtained from the designated doctor who opined the patient had reached MMI as of May 31, 2011, with 4% WPI rating. refilled medications and recommended further surgery.

On November 23, 2011, evaluated the patient for bilateral knee pain. He noted that when doing a WHP activity, the patient hyperextended his left knee performing a leg extension exercise and felt greater acute discomfort with edema. diagnosed tear of the medial cartilage/meniscus, internal derangement of knee and sprain/strain of cruciate ligament. He recommended evaluation by an orthopedic surgeon.

performed a MMI/IR evaluation and opined the patient was not at MMI.

performed a peer review and rendered the following opinions: (1) Left knee arthroscopy, chondroplasty of the patella, possible lateral and medial meniscus repair or meniscectomy and possible ACL reconstruction was not medically necessary. (2) The patient was not assessed for five months and current exam with the present symptoms was recommended in addition to a second opinion regarding a surgical plan. (3) In an FCE, the patient qualified at light PDL and was recommended more aggressive course of lower extremity strengthening and stabilization.

On December 22, 2011, noted clinically the patient had ACL laxity consistent with partial ACL injury of the posterolateral bundle with hyperextension/torsion injury. The MRI showed very tight straight ACL in extension (an appearance sometimes due to posterolateral bundle injury). opined the partial injuries were missed approximately 90% on MRI and such lesions required arthroscopy for diagnosis and treatment. He therefore recommended knee arthroscopy and/or other procedures as may be found necessary. prescribed tramadol, Ambien and Zoloft. The patient was scheduled to have a benefit review conference (BRC) in January 2012.

Per utilization review, the request for additional PT was denied.

2012: Per utilization review dated January 4, 2012, the request for diagnostic arthroscopy of the left knee with or without synovial biopsy was denied with the following rationale: *"The request for left knee arthroscopy and/or other procedures (as may be found) is not medically necessary at this time. The documentation submitted for review indicates the patient underwent synovectomy and chondroplasty of the left knee on October 18, 2010. An MRI of the left knee dated May 2, 2011, indicated the patient had focal osteochondral lesion, mild joint effusion, no evidence of meniscus tear and intact ACL and posterior cruciate ligament (PCL). The independent medical evaluation did not reveal any evidence suggestive of internal derangement on physical exam to warrant a surgical intervention. There is also a lack of documentation of recent conservative care at this time. As such, the documentation provided does not support the request at this time."*

On January 11, 2012, performed MMI/IR evaluation and opined the patient was not at MMI. Per the patient had reinjured his left knee during postop rehab. He was working with a leg extension machine when he felt a "pop" in his left knee. The surgeon diagnosed the patient with a probable ACL tear, though to be very likely considering the previous findings on the first MRI and the mechanism of injury. Since this re-injury occurred during rehab, the patient needed another MRI and should not have been placed at MMI. further added that the right knee should also be included in the injury.

On January 23, 2012, left knee sharp, throbbing, moderate-to-severe pain worse with weightbearing. Exam showed reduced ROM, trace lateral patellar tracking, and point tenderness in the medial meniscus. recommended obtaining MR arthrogram of the left knee with x-rays and returning in three to four weeks with results.

Per reconsideration review dated January 24, 2012, the appeal for left knee arthroscopy and/or other procedure was denied with the following rationale: *“The Official Disability Guidelines (ODG) recommend a knee arthroscopy provided the patient meets specific criteria to include inconclusive imaging studies. The most recent imaging studies following the previous knee arthroscopy revealed findings consistent with an osteochondral lesion at the medial articular surface of the patella. No meniscal tear, ligamentous tear, or tendinous involvement was noted. Given the lack of significant findings revealed on the imaging studies, this request does not meet guideline recommendations. As such, the documentation submitted for review does not support this request at this time.”*

On February 22, 2012, noted ACL laxity, positive findings for ACL dysfunction and tenderness in the medial meniscus area. assessed anterior left knee pain, ACL laxity and medial/lateral meniscal tear. He recommended arthroscopy and repair of the left knee and placed the patient off work through May 30, 2012.

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

THE REQUEST IS FOR A REPEAT ARTHROSCOPY AND POSSIBLE ACL RECONSTRUCTION FOR THIS PATIENT'S LEFT KNEE. ON REVIEWING THIS CLAIMANT'S INITIAL ARTHROSCOPY DONE ON OCTOBER 18, 2010, BY IT SHOWED NO TEARING OF THE MEDIOLATERAL MENISCI. THE OPERATIVE NOTE DESCRIBED THE ACL AS BEING EXTENSIVELY EVALUATED WITH PROBING AS WELL AS STRESS TESTING SHOWING NO FINDINGS OF INSTABILITY. A REPEAT POST OPERATIVE MRI SHOWED A FOCAL OSTEOCHONDRAL LESION OF THE MEDIAL ARTICULAR SURFACE OF THE PATELLA WITH NO MENISCAL TEAR SEEN. THE ACL AND PCL APPEARED TO BE INTACT. WITH THE PREVIOUS ARTHROSCOPY SHOWING NO SIGNIFICANT DAMAGE TO THE ACL THAT WOULD BE CAUSING INSTABILITY AND A POST OPERATIVE MRI SHOWING NO ACL OR MENISCAL INJURY, THE NEED FOR A REPEAT ARTHROSCOPY DOES NOT APPEAR TO BE REASONABLE OR NECESSARY.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES