





**MEDICAL EVALUATORS  
OF T E X A S** ASO, L.L.C.

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**EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This is a female who sustained injury on xx/xx/xx when she slipped and fell on an uneven surface in a parking lot. She reported injury to her neck, back, right elbow, and knees. She went to the ER at Hospital and had x-rays. Since the fall, her right knee pain intensified but done well in regards to other injuries. She had right knee MRI on 05/24/2013 that showed, "complete tear of the anterior cruciate ligament. This is likely chronic as there is no joint effusion, and no marrow edema pattern as usually seen with an acute ACL tear. Chronic macerated tear of the posterior horn of the medial meniscus, and there is chronic degeneration of the entire medial meniscus. There is medial compartment joint space narrowing with chondromalacia and osteophyte formation without full-thickness cartilaginous loss. Oblique tear through the body of the lateral meniscus extending to the inferior articular surface." Her treatment history includes medications and physical therapy. She was seen on 06/11/2013 and was recommended diagnostic and operative arthroscopy to completely evaluate the internal structures. She had a designated doctor evaluation on 08/09/2013 and was placed at MMI as of 07/10/2013 with 0% IR. A most recent note dated 03/26/2014 indicates she continues to have positive MacIntosh lateral pivot shift test and positive McMurray test. There was a 1+ joint effusion. There was tenderness medially and laterally. MCL and LCL were stable. Anterior Drawer was +3 and posterior Drawer was negative. continued to recommend diagnostic arthroscopy with possible ACL reconstruction. There are two previous denials. The request was previously non-certified due to lack of diagnostic evidence of objective documentation to support the procedure as per ODG.



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

This is a female with a chronic ACL tear in the setting of mild medial compartment osteoarthritic findings. A review of the clinical history reveals that the patient is having pain, but it was not clearly established that the patient is having subjective instability symptoms. It is also not clearly stated that the patient participates in any aggressive activity that would require cutting/pivoting/lateral movements. The patient has undergone conservative treatments including physical therapy and water aerobics per the included reports. MRI demonstrates no effusion or bone bruising pattern indicative of an acute tear. She has medial and lateral meniscus tears and corresponding positive McMurray and medial/lateral joint line tenderness on exam.

Given that this is likely a chronic ACL tear in the setting of osteoarthritis in an older patient without the obvious need for aggressive, cutting activity, I do not think that an ACL reconstruction is warranted according to ODG. She has failed a course of conservative treatment, however, and she continues to have medial and lateral joint line pain. Given the MRI findings for both medial and lateral meniscal tears, I do think that arthroscopy with meniscal debridement is warranted. Chondral status could also be evaluated at that time, and the patient may get relief from her joint line pain. If the patient failed to get relief from a surgery of that nature, then I would anticipate she would likely be candidate for total knee arthroplasty in the future to address her arthritis.

**ODG – Knee & Leg (Acute and Chronic)**

**Diagnostic arthroscopy**

Recommended as indicated below. Second look arthroscopy is only recommended in case of complications from OATS or ACL procedures, to assess how the repair is healing, or in individual cases that are ethically defensible for scientific reasons, only after a thorough and full informed consent procedure. (Vanlauwe, 2007) In patients with osteoarthritis, the value of MRI for a precise grading of the cartilage is limited, compared to diagnostic arthroplasty. When the assessment of the cartilage is crucial for a definitive decision regarding therapeutic options in patients with osteoarthritis, arthroscopy should not be generally replaced by MRI. The diagnostic values of MRI grading, using arthroscopy as reference standard, were calculated for each grade of cartilage damage. For grade 1, 2 and 3 lesions, sensitivities were relatively poor, whereas relatively better values were noted for grade 4 disorders. (von Engelhardt, 2010)

ODG Indications for Surgery -- Diagnostic arthroscopy:

Criteria for diagnostic arthroscopy:

1. Conservative Care: Medications. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS
3. Imaging Clinical Findings: Imaging is inconclusive.  
(Washington, 2003) (Lee, 2004)



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

### **Anterior cruciate ligament (ACL) reconstruction**

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. (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) Young athletes who need ACL reconstruction have better long-term outcomes with autologous grafts (self donor) versus allograft (cadaver). Patients who had ACL allograft reconstruction were almost seven times as likely to need a second surgery compared to autograft reconstruction. (Pallis, 2012)

Age: Outcomes are worse in older patients (age beyond 50-60 years) but still may justify the procedure. ACL reconstruction can be successful in appropriately selected, motivated



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older patients with symptomatic knee instability who want to return to participating in highly demanding sport and recreational activities. (Legnani, 2011) Age alone should not exclude ACL-deficient patients from undergoing reconstructive surgery. (Gee, 2013) Patients aged 40 years and older with an ACL injury can have satisfactory outcomes after reconstruction. (Brown, 2013) Optimal surgical results can in fact be achieved even in older patients. (Desai, 2013)

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).



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**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)