

**Maturus Software Technologies Corporation  
DBA Matutech, Inc  
881 Rock Street  
New Braunfels, TX 78130  
Phone: 800-929-9078  
Fax: 800-570-9544**

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**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

ACL reconstruction, LCL repair, hardware removal

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

Certified, American Board of Orthopaedic Surgery

**REVIEW OUTCOME:**

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

X Upheld (Agree)

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**Official Disability Guidelines (ODG) were used for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a XX on the X team who was training and got his leg pinned under three other guards and felt his left knee pop.

On XX/XX/XX, XX gave the patient a prescription for a hinged knee brace.

Following the injury to his left knee, the patient was evaluated at the emergency room by various providers. He reported severe pain and swelling in the left posterolateral knee. He was unable to bear weight on the affected extremity. Examination revealed left lower extremity posterolateral tenderness and swelling, effusion, and range of motion limited/restricted by pain. The lateral collateral ligament (LCL) was noted to have at least 10 mm widening of the left lateral joint space with laxity valgus stress. Posterior drawer sign was positive and had laxity. X-rays of the left knee were unremarkable. XX diagnosed a left knee injury with suspected LCL, posterior cruciate ligament (PCL) and meniscus tear. He was discharged home with knee wraps (elastic bandage) and rest, ice, compression and elevation (RICE) and knee immobilization (custom). He was given restrictions including limited activity, limited work, no weightbearing on the left knee to be on crutches and sitting at work.

On XX/XX/XX, XX completed an addendum to the Work Status Form documenting the patient could stand 1 hour a day, walk 7 hours a day with no reaching/overhead reaching.

On XX/XX/XX, XX provided an orthopaedic evaluation of the patient, who reported he was still not able to bear weight on his leg. Examination revealed some bruising at the left knee. The patient was on crutches and demonstrated a bent-knee gait favoring the left lower extremity. Knee flexion was limited due to pain and tightness. There was positive effusion of approximately 40-50 ml, a positive medial and lateral McMurray's, positive for moderate posterior lateral joint line tenderness to palpation, positive posterior drawer, positive Lachman's, significant hamstring weakness, positive posterior sag. Dial testing at 30° demonstrated a 15° increase and dial testing at 90° demonstrated a 10° increase. X-rays of the left knee identified a well-aligned knee joint with no evidence of fracture or dislocation. There were no degenerative changes seen. There was some soft tissue trauma noted. His knee was pretty swollen on the left side compared to the right. XX assessed acute left knee injury with multi-ligament damage including the lateral and collateral ligaments, probably popliteus and PCL; and effusion. He recommended obtaining an MRI of the left knee and continued him on the knee immobilizer. He also opined the patient needed surgery and advised postoperative physical therapy (PT).

On XX/XX/XX, an MRI of the left knee was completed at XX. The study revealed ACL tear, diffusely abnormal PCL consistent with very high-grade injury. Complete avulsion of the conjoined tendon and fibular collateral ligament off the fibula tear of the iliotibial band, avulsion of popliteal tendon at the femoral origin with probable small flake of bone, associated tear of the lateral joint capsule with joint fluid extending into the lateral subcutaneous tissues over the fibular head. Partial discoid lateral meniscus, no meniscal tear visible. Medial femoral condyle bone bruise. No fracture line, no cartilage defects visible. Large joint effusion.

On XX/XX/XX, XX saw the patient for a PT initial evaluation and recommended PT three times a week for four weeks. Modalities recommended included group therapy, therapeutic exercises, manual therapy, cold pack, electrical stimulation, therapeutic activities, aquatic PT and neuromuscular re-education. From XX/XX/XX, - XX/XX/XX, the patient underwent PT visits.

On XX/XX/XX, XX saw the patient who reported the therapy was going well. He had some soreness and it sometimes bothered him while sleeping. He had ongoing discomfort to his knee. He stated the brace was rubbing him and he was having a hard time with it. XX assessed left knee complete ACL tear, complete LCL tears and a PCL tear with maybe some functioning fibers and recommended surgical intervention. He ordered a Jack PCL brace, scheduled the patient for surgery, advised him to continue to work ROM and maintained him off work.

The patient was hospitalized from XX/XX/XX-XX/XX/XX. On XX, XX performed a left knee arthroscopic ACL reconstruction, arthroscopic PCL reconstruction, open lateral collateral ligament repair and peroneal nerve neurolysis.

On XX/XX/XX, and XX/XX/XX, XX performed a PT re-evaluation, recommending PT three times a week for four weeks. Modalities suggested were group therapy, therapeutic exercises, neuromuscular re-education,

therapeutic activities, electrical stimulation and hot/cold pack. From XX/XX/XX-XX/XX/XX, the patient underwent PT visits.

On XX/XX/XX, XX evaluated the patient for his left knee three months post multi-ligament reconstruction. The patient reported his knee was doing overall better. He only had pain when he walked for long periods of time. He continued use of his long hinged knee brace. He felt he was getting a little bit more bow-legged and he was concerned. XX assessed left knee status post failed lateral collateral ligament reconstruction with high-grade opening on weightbearing images and new varus alignment in his knee of 5 cm. The plan was to obtain x-rays of the hips to ankles. XX recommended progressing with the patient's strengthening, putting him back in his hinged brace and having him offload the knee joint with a single crutch. He was maintained off work.

On XX/XX/XX XX evaluated the patient. He had completed weightbearing images that were reviewed. XX felt his weightbearing axis was deviated medially significantly and he might have to have a proximal tibial realignment. He was allowed to walk full weightbearing with his normal gait and switch back to a regular hinged knee brace.

On XX/XX/XX, XX evaluated the patient for an orthopedic consultation. The patient's main complaint was instability and also the varus deformity of his leg. He had not returned back to work at that time given his injury. Examination revealed upon standing, the patient had a varus deformity about the left knee and with gait, also had a varus thrust. He had good range of motion about the knee from 0-120 degrees. Slight effusion compared to the contralateral side. Good patellar range of motion was noted, although it was decreased from the contralateral side. In regards to the PCL, he had a positive posterior drawer, grade 2. He opened to varus in both 0 and 30 degrees of flexion. He was stable to valgus at 30 degrees of flexion. No significant opening at 0 degrees. He did have a 2A Lachman's. Full length standing films did reveal significant varus deformity about the left knee along with opening of the lateral compartment. The assessment was continued instability resulting in varus malalignment and varus thrust. Various treatment options were discussed with the patient. He was told this would likely require more than one surgical procedure to correct his malalignment and laxity. Computerized tomography (CT) and magnetic resonance (MRI) of the left knee were ordered.

On XX/XX/XX, standing bilateral hip to ankles scanogram revealed post-traumatic and postsurgical changes about the left knee with significant genu varus and no significant leg-length discrepancy.

On XX/XX/XX, XX documented an e-mail to XX and XX noting the patient stated XX office had not configured his appointment on XX/XX/XX, under Workers' Compensation. He had been instructed to obtain current blood work, MRI and CT scan of his left lower extremity and return to XX on completing these.

On XX/XX/XX, CT of the left knee interpreted by XX and revealed postoperative change of the left knee; superior-most screw in the lateral femoral condyle appeared fractured and there was some cortical irregularity of the lateral femoral condyle at the insertion site of the screw; thinning of the anterior aspect of the medial joint compartment with some associated bony sclerosis involving the medial femoral condyle and medial tibial plateau.

On the same date, an MRI of the left knee was completed at XX. The study revealed wide lateral compartment

with synovial proliferation into the compartment toward the intercondylar aspect fibular collateral ligament reconstruction without disruption nodular thickening along peripheral, capsular margin of lateral meniscus. ACL reconstruction appeared intact with nodular soft tissue thickening along the anterior margin above the tibial insertion. PCL showed mild thinning at the femoral origin along the inferior margin but otherwise appeared intact. Trace joint effusion. No meniscal tear mild bone bruises and reactive edema in the lateral more than medial femoral condyles.

On XX/XX/XX, XX documented an e-mail to XX and XX noting the patient was ambulating with the assistance of a crutch of the left side and wearing the knee brace. He was partial weightbearing to the left lower extremity. The patient noted he had been diagnosed with left lobe pneumonia effective XX/XX/XX by XX and been treated with Levaquin as well as over-the-counter (OTC) Mucinex.

On XX/XX/XX, XX saw the patient. The patient had completed imaging and lab work. Review of lab work showed that he did have an elevated white count that was 12, but his CRP and sedimentation rate were both normal. He did have a small amount of left shift that was noted in his white count. Examination still revealed the patient walking with a varus thrust. He still had some deficiency of the lateral structures with varus force. His quad tone and hamstring tone were a little bit weakened, but they were progressing. XX assessed left knee status post ACL reconstruction with bone-tendon-bone autograft and lateral collateral ligament reconstruction with cadaver and a PCL repair with an anchor. XX encouraged the patient to keep his appointment with XX.

On XX/XX/XX, XX evaluated the patient for a preadmission H&P. The patient denied any significant pain other than the instability and the deformity to his leg. He had not been able to return back to work up. MRI, CT scan and standing images were reviewed for preoperative planning. The patient was scheduled for surgery.

On XX/XX/XX, the patient underwent left knee high tibial osteotomy by. The postoperative diagnoses were left knee multi-ligament injury knee dislocation, status post ligament reconstruction with varus malalignment and ligament laxity. The patient underwent OT and PT inpatient evaluations and was recommended to undergo skilled therapy for the length of his stay. He was discharged home in a stable condition on XX/XX/XX, with discharge medications including docusate, enoxaparin, meloxicam, ondansetron and oxycodone.

Per E-mail correspondence dated XX/XX/XX, XX wrote to XX that the patient had undergone surgery that was non-certified from preauthorization and that paperwork on appeal was required.

On XX/XX/XX, x-rays of the left knee revealed uncomplicated appearance of tibial osteotomy and postsurgical change from lateral ligamentous reconstruction with persistent lateral joint space widening.

On XX/XX/XX, XX evaluated the patient. The patient was overall doing well, using crutches. He had a feeling of instability that was expected, but overall his pain was well controlled. XX assessed left knee high tibial osteotomy with plan for revision reconstruction of his ligaments once he was 6 months out from surgery. He continued to have limitation in ambulation using a crutch and a brace. XX opined the patient was not able to go back to work at that time and anticipated him being off of work until his next visit in late XX after which XX anticipated planning his revision. He would remain off of work after that surgery.

Per E-mail correspondence dated XX/XX/XX, XX documented that per discussion with the patient, he would not be considered for return to work until after the pending second surgery and that he had received a note from XX to remain off work.

Per E-mail correspondence dated XX/XX/XX, XX documented the patient had been advised to bring new typographically correct documentation and bring all the brace devices to XX appointment. XX confirmed the patient continued off work per XX.

On XX/XX/XX, XX evaluated the patient. The patient reported he felt like his tibia was improved in alignment. He stated he still felt it shifting around on him. Examination revealed the incision was healed, and his gait was much better. His mechanical alignment felt normal. He had no varus thrust. He still had high-grade lateral ligament injuries. There was increased anterior translation as well. The PCL had a small amount of drop back. X-rays of both knees revealed evidence of a high tibial osteotomy that had corrected the alignment. This appeared healed without any evidence of loosening. XX felt the patient was doing pretty well as far as the high tibial osteotomy and advised him to follow up after the procedures on an as-needed basis.

On XX/XX/XX, XX recommended revision ACL reconstruction and revision posterolateral corner (PLC, not PCL) reconstruction, and

Per Utilization Review dated XX/XX/XX, XX denied the following requested medical treatment: Left Knee Anterior Cruciate Ligament (ACL), Lateral Collateral Ligament (LCL) and Posterior Cruciate Ligament (PCL) Reconstruction with External Fixator between XX/XX/XX-XX/XX/XX. Rationale: *“Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, this request is non-certified. While the patient complains of left knee symptoms, there was no evidence in the medical reports submitted that the patient has exhausted post-operative conservative management including physical therapy and bracing prior to the proposed surgery. Also, an MRI of the left knee was not submitted for review. In consideration of the foregoing issues and the referenced evidence-based practice guidelines, the medical necessity of the requested surgeries has not been established.”*

Per utilization review dated XX/XX/XX, XX performed a reconsideration review and upheld the denial with the following rationale: *“Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. There remained to be no evidence of failure of recent conservative care to support the requested surgery. In addition, an MRI of the left knee documenting ACL, LCL and PCL derangements had not been documented in the updated records.”*

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

The injured worker needs a revision ACL reconstruction and a posterolateral corner (PLC) revision reconstruction.

The most recent office note on XX/XX/XX identified symptoms and exam findings that are consistent with the procedure requested: a revision reconstruction of the ACL and the posterolateral corner. These procedures appear to be medically reasonable and necessary.

However, it appears that the procedures presented to the URA for approval are different: Left knee ACL, LCL, and PCL (posterior cruciate ligament) reconstruction with external fixator. These procedures are not documented or discussed in the preoperative records, and were appropriately denied by the URA.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**