MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 7/20/18

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of right knee arthroscopy with revision ACL reconstruction using MTF tibialis anterior allograft, hardware removal of embedded screws in tibia and femur, meniscal repair vs. partial meniscectomy, chondroplasty, abrasion arthroplasty, synovectomy and removal of loose bodies under general anesthesia with C arm, surgical assistant, sequential compression device, and a knee immobilizer.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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 reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of right knee arthroscopy with revision ACL reconstruction using MTF tibialis anterior allograft, hardware removal of embedded screws in tibia and femur, meniscal repair vs. partial meniscectomy, chondroplasty, abrasion arthroplasty, synovectomy and removal of loose bodies under general anesthesia with C arm, surgical assistant, sequential compression device, and a knee immobilizer.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX who was injured on XX, when stepping in XX in the ground and heard a pop in the right knee. The claimant was diagnosed with a right knee sprain. An MRI on XX, reported an anterior cruciate ligament graft rupture, pivot shift contusions, and medial meniscal high-grade full-thickness tear. There was medial femoral condyle full-thickness cartilage defect and a large joint effusion with synovitis, debris, and loose body. History of prior anterior cruciate ligament repair in XX was noted. X-rays reported mild arthritis with previous hardware from the anterior cruciate ligament repair. Ultrasound-guided aspiration of the right knee had been performed. Treatment had included physical therapy, injection, and medications with failure and right knee arthroscopy was recommended. Medications included XX and XX. The most recent record provided was the progress note from XX, which documented knee pain, swelling, and decreased range of motion. Popping and stiffness was also reported. There was positive instability, Lachman's, pivot sift, and anterior drawer testing. Strength was 4/5 in the right lower extremity. McMurray's was positive.

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

The request was previously noncertified on XX, due to lack of documented conservative treatment. No additional documentation was provided; however, the physician does note that the claimant has failed oral medication, physical therapy, activity modification, and immobilization. The claimant has had persistent instability despite treatment to date. There has been prior anterior cruciate ligament reconstruction; therefore, hardware removal would be provided in order to facilitate anterior cruciate ligament reconstruction in accordance with the guidelines. There is meniscal pathology, in addition to chondral defect; therefore, the chondroplasty and repair versus meniscectomy would be warranted. Abrasion arthroplasty would be warranted as well. There is evidence of loose body, synovitis; therefore, synovectomy and removal of loose bodies to be performed under the concomitant treatment of the anterior cruciate ligament deficiency and meniscal tear would be warranted. This could be performed under general anesthesia with the use of a C-arm surgical assistant. The postoperative use of a sequential compression device would be warranted in accordance with the guidelines, in addition to a knee immobilizer. The claimant meets the guideline treatment recommendations to proceed with the requested surgeries to be performed in combination with the surgeries for the anterior cruciate ligament and meniscal pathology. The request for right knee arthroscopy with revision ACL reconstruction using MTF tibialis anterior allograft, hardware removal of embedded screws in tibia and femur, meniscal repair vs. partial meniscectomy, chondroplasty, abrasion arthroplasty, synovectomy and removal of loose bodies under general anesthesia with C arm, surgical assistant, sequential compression device, and a knee immobilizer is medically necessary per ODG.

Official Disability Guidelines, ODG Treatment, Integrated Treatment/Disability Duration Guidelines; Knee and Leg (Acute and Chronic); (updated 07/05/18)
Hardware implant removal (fracture fixation)
Not recommended for routine removal of hardware implanted for fracture fixation, except with exposed or prominent pins, broken hardware, or persistent pain after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection. Although hardware removal is commonly performed, it should not be considered a routine procedure. For more information and references, see the Ankle and Foot Chapter.
Anterior cruciate ligament reconstruction (ACLR)
Recommended as indicated below.
See also ACL diagnostic tests; ACL injury rehabilitation; Knee brace; and Surgery for arthrofibrosis.
ODG Indications for Surgery™ -- Anterior cruciate ligament reconstruction (ACLR):
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, 2003b) (Woo, 2000) (Shelbourne, 2000) (Millett, 2004)
For average hospital LOS if criteria are met, see Hospital length of stay (LOS).
Meniscectomy
Recommended as indicated below for symptomatic meniscal tears in younger patients, primarily for traumatic tears. Not recommended for osteoarthritis (OA) in the absence of solid mechanical meniscal findings or in older patients with degenerative tears who are more appropriately treated with physical therapy/exercise. (Kirkley, 2008) (Khan, 2014)
See Meniscal allograft transplantation. See also Arthroscopic surgery for osteoarthritis; Loose body removal surgery (arthroscopy).
ODG Indications for Surgery™ -- Meniscectomy:
Criteria for meniscectomy or meniscus repair (It is recommended to require 2 symptoms and 2 signs to avoid arthroscopy with lower yield, e.g., pain without other symptoms, posterior joint line tenderness that could signify arthritis, or MRI with degenerative tear, which is often a false positive). Physiologically younger and more active patients with traumatic injuries and mechanical symptoms (locking, blocking, catching, etc.) should undergo arthroscopy without PT.

1. Conservative Care: (Not required for locked/blocked knee.) Exercise/Physical therapy (supervised PT and/or home rehab exercises, if compliance is adequate). AND (Medication. OR Activity modification [e.g., crutches and/or immobilizer].) PLUS
2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of giving 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 (order MRI only when above criteria are met). (XX)
For average hospital LOS if criteria are met, see Hospital length of stay (LOS).
Chondroplasty
Recommended rarely as indicated below. Not recommended as a primary treatment for osteoarthritis or as an isolated procedure (unless large unstable chondral flap on MRI with definite mechanical symptoms), since arthroscopic surgery for knee osteoarthritis and articular chondral degeneration offers no added benefit to optimized physical therapy and medical treatment. (Kirkley, 2008) A quality RCT comparing debridement vs. simple observation of unstable chondral lesions encountered during arthroscopic partial meniscectomy resulted in no differences of 1-year outcomes. The authors suggested that debridement added no benefit and that such lesions should be left in situ. (Bisson, 2017)
See also Meniscectomy.
ODG Indications for Surgery™ -- Chondroplasty:
Usually combined with other indicated knee procedures rather than as a stand-alone procedure
Criteria for chondroplasty (shaving or debridement of an articular surface), requiring ALL of the following:
1. Conservative Care: Medication. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Joint pain. AND Swelling. AND Mechanical catching. PLUS
3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS
4. Imaging Clinical Findings: Large unstable chondral defect on MRI. (Washington, 2003b) (Hunt, 2002) (Janecki, 1998)
For average hospital LOS if criteria are met, see Hospital length of stay (LOS).
Synovectomy
Recommended as indicated below for specific conditions. Not recommended as a primary treatment for osteoarthritis or as an isolated procedure (unless specific criteria are met, e.g., medial plica syndrome), since arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical therapy and medical treatment.
See also Arthroscopic surgery for osteoarthritis; Surgery for arthrofibrosis; and Diagnostic arthroscopy.
ODG Indications for Surgery™ -- Synovectomy:

Synovectomy is usually combined with other indicated knee procedures rather than being performed as a stand-alone procedure, except for specific medical conditions reviewed below.
Criteria for synovectomy, requiring ALL of the following:
1. Conservative Care: A minimum of 6 weeks including Medications including failed corticosteroid injection (unless contraindicated). AND/OR Physical therapy. AND/OR Bracing. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS Joint pain. AND Swelling. PLUS
3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS
4. Imaging Clinical Findings: Absence of moderate-to-severe arthritic changes on X-ray or MRI.
For average hospital LOS if criteria are met, see Hospital length of stay (LOS).
Loose body removal surgery (arthroscopy)
Recommended where symptoms are noted consistent with a loose body, after failure of conservative treatment, but knee arthroscopic surgery for treatment of osteoarthrosis is not recommended. In cases of knee osteoarthritis where mechanical symptoms are consistent with a loose body, meniscal tear or chondral flap tear, arthroscopy after failure of non-operative treatment is indicated. This is especially true if the pathology is in a compartment (i.e., lateral) other than one with advanced joint space collapse (i.e., medial).
See also Arthroscopic surgery for osteoarthritis.
Continuous-flow cryotherapy
Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated.
Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. (Hubbard, 2004) (Morsi, 2002) (Barber, 2000) The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. (XX) This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, is easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of knee surgery. (Raynor, 2005) There is limited information to support active vs passive cryo units.XX considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. (XX, 2006) This study concluded that continuous cold therapy devices, compared to simple icing, resulted in much

better nighttime pain control and improved quality of life in the early period following routine knee arthroscopy. (Woolf, 2008) Two additional RCTs provide support for use after total knee arthroplasty (TKA). Cold compression reduced blood loss by 32% and pain medication intake by 24%. (Levy, 1993) It improved ROM and reduced hospital stay by 21%. (Kullenberg, 2006) See also Cold/heat packs.

Immobilization

Not recommended as a primary treatment. Immobilization and rest appear to be overused as a treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. (Nash, 2004)

ODG Treatment

Integrated Treatment/Disability Duration Guidelines

Low Back - Lumbar and Thoracic (Acute and Chronic)

(updated 07/06/18)

Surgical assistant

Recommended as an option in more complex surgeries as identified below. An assistant surgeon actively assists the physician performing a surgical procedure. Reimbursement for assistant surgeon services, when reported by the same individual physician or other health care professional, is based on whether the assistant surgeon is a physician or another health care professional acting as the surgical assistant. Only one assistant surgeon for each procedure is a reimbursable service, without exceptions for teaching hospitals or hospital bylaws. The following low back surgical procedure CPT codes are eligible for a surgical assistant: 20930; 20931; 20936; 20937; 20938; 22224; 22226; 22548; 22558; 22585; 22612; 22614; 22630; 22632; 22830; 22840; 22841; 22842; 22843; 22844; 22845; 22846; 22847; 22849; 22850; 22851; 22852; 22855; 63005; 63011; 63012; 63017; 63030; 63035; 63042; 63044; 63047; 63048; 63056; 63057; 63170; 63185; 63190; 63200; 63267; 63268; 63272; 63273; and 69990. (CMS, 2014)

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)**