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February 11, 2015

Upon request of IAAI a medical opinion regarding the treatment provided was conducted on the above patient. Our findings are documented below:

Clinical Summary:

The patient is a 56-year-old male. He has noted chronic ACL (anterior cruciate ligament) deficiency with a history of prior knee arthroscopy by the operative surgeon in 2005. He presented on the day of a fall, 10/10/2014 to this surgeon with complaints of right knee pain. He was found to have knee pain, effusion, and decreased ROM (range of motion) and exam findings consistent with ACL deficiency. An MRI (magnetic resonance imaging) scan was ordered. This showed evidence of prior medial meniscal debridement, ACL deficiency, an "ulcer" of the medial femoral condyle (MFC), and bone bruises. He followed-up after the MRI and was found to have continued pain and poor ROM at 15 to 70 degrees. A well-documented rationale for surgical intervention is noted, with plans for meniscal debridement, ACL reconstruction, loose body removal and possible microfracture. The patient received an intra-articular steroid injection at that preoperative visit. On 10/23/2014, he underwent scope BPTB (bone–patellar tendon–bone) allograft ACL reconstruction, chondroplasty with microfracture of the MFC, loose body removal, and lateral meniscal debridement. He was seen postoperatively on 10/27/2014 and was found to be doing ok, with appropriate x-ray findings. Postoperative CPM (continuous passive motion) use and PT (physical therapy) were ordered three times a week for eight weeks.

Questions:

1. For surgery performed on 10/23/14 are all codes medically necessary? Please include all services performed by surgeon, assistant and facility.

2. Was the assistant surgeon medically necessary?

3. Are all the codes on the facility bill medically necessary?

4. Are all services leading up to surgery medically necessary?

Conclusions*:

1. For surgery performed on 10/23/14 are all codes medically necessary? Please include all services performed by surgeon, assistant and facility.

Yes. For surgery performed on 10/23/2014, all codes were medically necessary. The patient is

7 KIMBALL LANE • BUILDING A • LYNNFIELD, MA 01940
781.224.9711 • 855.224.9711 • 781.224.9713
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a 56-year-old male with chronic ACL deficiency who presented with acute complaints after a knee injury. An MRI was appropriately ordered to elucidate the pathology given the clinical exam findings, effusion, and decreased ROM. It found the known suspected ACL deficiency, but also a significant acute MFC lesion with intra-articular loose body. The findings changed and delineated the plan and support the need for MRI. The MFC lesion, block to motion, and intra-articular loose body are the most appropriate indications for surgical intervention.

ACL reconstruction in a 56-year-old male with known chronic ACL deficiency and cartilaginous lesions is very debatable. The MRI report does not delineate the significance of the patient's chronic knee arthritis, if present. The surgeon notes his rationale for performing ACL reconstruction well in his preoperative note, citing falls due to the level of instability present. Again, the reconstruction is debatable, but in the absence of any information to the contrary it is not contraindicated, and the surgeon justifies his rationale. The codes for ACL reconstruction, meniscal debridement, abrasion/microfracture, and loose body removal are all appropriate. They were suspected preoperatively, correlated with MRI findings, and were performed at the time of surgery.

2. Was the assistant surgeon medically necessary?

Yes. A PA (physician assistant) is medically necessary operatively for many reasons. In this particular case, the aid in preparing for and inserting an ACL graft is particularly necessary.

3. Are all the codes on the facility bill medically necessary?

Yes. As noted above, the procedures performed and billing are accurate and medically necessary.

4. Are all services leading up to surgery medically necessary?

Yes. An initial visit occurred, and this was well-documented. The MRI is justified as per above. The knee steroid injection was indicated given the patients level of pain and loss of motion, and it also helped establish an apparent mechanical block to motion caused by the loose body.

Reference(s):

1. Prodromos et al. Controversies in ACL Recon. JAAOS 2008; 16(7): 375+.

Reviewer's Credentials

Is a medical doctor (MD) board certified in orthopedics with an active practice treating adults and children. Completed a joint reconstruction fellowship. Serves as a staff orthopedic surgeon at a regional medical center. Published in peer reviewed literature. Is active in professional societies. Lectures by invitation.

**The conclusions in this report may be modified or updated if additional historical or analytical data becomes available. The recommendations noted are made to a reasonable degree of medical certainty. These opinions are based on the medical records and information submitted to AMS for review, Physician/clinician contractors also consider published scientific medical evidence and other relevant information such as that available through federal government agencies, institutes, and professional associations. Advanced Medical Strategies, LLC. assumes no liability for the opinions. The client authorizing this case review agrees to hold AMS harmless for any and all claims which may arise as a result of this case review. This opinion is not intended to be final interpretation of plan/policy language or determination of benefits or exclusions. Adjudication of the claim remains solely the client's responsibility.*

Stacy M. Borans, MD
Chief Medical Officer
Advanced Medical Strategies
781-224-9711 Ext. 101
stacy.borans@mdstrat.com