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Notice of Independent Review Decision

DATE OF REVIEW: 05/19/2008

IRO CASE #:

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

This case was reviewed by a Orthopaedic Surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat left knee arthroscopy, medial meniscectomy

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o June 26, 2007 MMI-Impairment evaluation report, Dr.
- o January 10, 2008 Progress report from Dr.
- o January 30, 2008 Progress report from Dr.
- o February 11, 2008 Left knee MRI interpreted by Dr.
- o February 25, 2008 Progress report from Dr.
- o April 7, 2008 Progress report from Dr.
- o April 8, 2008 Request for preauthorization, repeat left knee arthroscopy, medial meniscectomy
- o April 8, 2008 Memo regarding case management activities from Dr.
- o April 10, 2008 Denial of request for preauthorization, left knee arthroscopy
- o April 24, 2008 Request for reconsideration, left knee arthroscopy with letter of appeal
- o May 1, 2008 Denial for request of reconsideration left knee arthroscopy, partial meniscectomy, -the rationale is not available for review - only the determination letter is available for review
- o May 12, 2008 request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records available for my review, the patient is a xx -year-old employee who sustained an industrial injury to the left knee on xx/xx/xx. The patient underwent left knee arthroscopy in February of 2007 with partial lateral meniscectomy and chondroplasty. The medial meniscus was reported as normal at that time. Two weeks following the surgery, the patient reportedly fell and has had persistent symptoms in the left knee since.

A Designated Doctor evaluation was performed on June 18, 2007 with a report submitted on June 26, 2008. The patient reports pain in the left knee with squatting and kneeling and occasional popping. A partial horizontal tear and/or mucoid degeneration was seen on MRI in the medial (sic) meniscus; possible partial ACL tear; possible partial tear/sprain of the medial collateral ligament. In February of 2007 left partial lateral meniscectomy was performed arthroscopically as well as tibial chondroplasty. The patient reported that by May of 2007 she had full left knee motion and no more fluid. The patient's medical history includes

Lupus erythematosus for the past 15 years. The patient is 5' 5" in height and 185 pounds. The left knee was not swollen and demonstrated motion of 0 to 110 degrees. A 1% whole person impairment was assigned.

Per progress report of January 10, 2008 the patient demonstrated full range of motion on examination and no effusion.

On January 30, 2008 it was reported that the patient's condition remains the same with continued left knee pain. She reports her knee continues to hurt and gives out. Ten days prior she fell and injured her right knee which is being attended by another physician.

Per a progress report of February 25, 2008 the patient continues to complain of significant pain in the left knee. She has had several episodes of her left knee giving away. The new MRI shows pathology in the medial meniscus. At the prior surgery the medial meniscus was normal. However, at 2 weeks post-op she fell and apparently injured the medial meniscus which is probably the reason for her continuing symptoms over the past year. She has clinical and MRI evidence of medial meniscus pathology.

Left knee MRI of February 11, 2008 shows mild narrowing of the medial joint space with a longitudinal tear through the posterior horn of the medial meniscus.

Progress report of April 7, 2008 states the patient reports extreme pain in the left knee with swelling. On examination, there is medial [joint line] tenderness. At this time, there is no effusion. There is normal stability. We have tried just about everything to get rid of the pain and she persists with symptoms.

On April 8, 2008 the patient's condition was discussed with the nurse case manager. The plan was to obtain approval for left meniscectomy and proceed with medical clearance.

Request for repeat left knee arthroscopic medial meniscectomy was not certified in review on April 10, 2008 with rationale that the medical records documented only medial tenderness with no effusion and normal stability of the left knee. The clinical findings were insufficient to warrant a surgical intervention. In addition, the MRI report does not describe the prior lateral intervention but does note a longitudinal tear in the medial meniscus.

The provider responded with a letter of appeal on April 24, 2008. It is agreed that there is not much in the way of physical findings; however the symptoms are fairly suggestive of medial meniscus tear and the MRI is also suggestive for meniscal pathology. If arthroscopy is not approved she should be considered MMI as far as the left knee is concerned. The MRI report not discussing prior surgical changes of the lateral meniscus is irrelevant.

Request for reconsideration for outpatient left knee arthroscopy was not certified in review on May 1, 2008.

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

The medical records document a patient who underwent left knee partial meniscectomy of the lateral meniscus, who reportedly has experienced left knee pain since falling 2 weeks post-op. When examined by the Designated Doctor 4 months post-op, the patient did not mention a fall or injury but reported that by 3 months post-op she had full left knee motion and no more fluid. During the Designated Doctor examination the knee demonstrated normal motion without effusion.

The provider's progress reports are very brief and focus on the patient's subjective report of symptoms. Effusion is not reported in any of the reevaluations. The progress reports fail to document the results of meniscal testing such as McMurray's test, and ligament patency is consistently reported as intact. The medical records lack objective clinical findings that correlate with the patient's reports of giving away of the left knee. The current MRI does show a longitudinal tear of the medial meniscus. The provider states just about everything has been tried to get rid of the pain. However, the medical records fail to clarify conservative measures attempted such as medications, injections, bracing, knee joint muscle strengthening exercises, or attempts of weight loss. The patient has an inflammatory autoimmune disease which can affect joints in an episodic manner.

ODG requires candidates for meniscectomy to have failed conservative care unless their knee is locked or blocked whence they can proceed directly to meniscectomy. Conservative care required is either medications, physical therapy or activity modification.

The medical records fail to document locking or blocking of the knee. Medications, physical therapy and activity modifications can be assumed although they have not been reported in the records reviewed.

ODG requires candidates for meniscectomy to have subjective clinical findings of joint pain or swelling or feeling of give way or locking, clicking or popping. The medical records do document subjective feeling of joint pain, swelling and give way.

ODG requires of successful candidates for meniscectomy that, on physical examination, there is demonstrated, positive McMurray's sign, [medial] joint line tenderness, effusion, limited range of motion, locking, clicking, or popping or crepitus. The medical records fail to document any of these criteria.

In addition to the ALL of the above requirements, meniscal pathology should be demonstrated on MRI. This requirement has been fulfilled.

The medical records fail to document objective clinical examination findings required by guidelines to warrant the patient as a successful candidate for the requested intervention. Therefore, my recommendation is to agree with the previous non-certification of the request for repeat left knee arthroscopy, medial meniscectomy.

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines - Meniscectomy 5-7-08:

Recommended as indicated below. Meniscectomy is a surgical procedure associated with a high risk of knee osteoarthritis (OA). One study concludes that the long-term outcome of meniscal injury and surgery appears to be determined largely by the type of meniscal tear, and that a partial meniscectomy may have better long-term results than a subtotal meniscectomy for a degenerative tear. (Englund, 2001) Another study concludes that partial meniscectomy may allow a slightly enhanced recovery rate as well as a potentially improved overall functional outcome including better knee stability in the long term compared with total meniscectomy. (Howell-Cochrane, 2002) The following characteristics were associated with a surgeon's judgment that a patient would likely benefit from knee surgery: a history of sports-related trauma, low functional status, limited knee flexion or extension, medial or lateral knee joint line tenderness, a click or pain noted with the McMurray test, and a positive Lachmann or anterior drawer test. (Solomon, 2004) Our conclusion is that operative treatment with complete repair of all torn structures produces the best overall knee function with better knee stability and patient satisfaction. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery will not be as beneficial for older patients who are exhibiting signs of

degenerative changes, possibly indicating osteoarthritis, and meniscectomy will not improve the OA. Meniscal repair is much more complicated than meniscal excision (meniscectomy). Some surgeons state in an operative report that they performed a meniscal repair when they may really mean a meniscectomy. A meniscus repair is a surgical procedure done to repair the damaged meniscus. This procedure can restore the normal anatomy of the knee, and has a better long-term prognosis when successful. However, the meniscus repair is a more significant surgery, the recovery is longer, and, because of limited blood supply to the meniscus, it is not always possible. A meniscectomy is a procedure to remove the torn portion of the meniscus. This procedure is far more commonly performed than a meniscus repair. Most meniscus tears cannot be treated by a repair. See also Meniscal allograft transplantation. (Harner, 2004) (Graf, 2004) (Wong, 2004) (Solomon-JAMA, 2001) (Chatain, 2003) (Chatain-Robinson, 2001) (Englund, 2004) (Englund, 2003) (Menetrey, 2002) (Pearse, 2003) (Roos, 2000) (Roos, 2001) Arthroscopic debridement of meniscus tears and knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for all patients with knee osteoarthritis. (Siparsky, 2007)

ODG Indications for Surgery -- Meniscectomy:

Criteria for meniscectomy or meniscus repair:

1. Conservative Care: (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. PLUS
2. Subjective Clinical Findings: Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS
3. Objective Clinical Findings: 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.