

P-IRO Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: September 23, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for outpatient surgical services left knee arthroscopy with meniscectomy

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Office notes, Dr. 11/21/05 to 1/21/06

Office notes, Dr. 1/24/06, 02/07/06, 02/14/06, 03/14/06, 05/02/06, 05/16/06, 06/20/06, 07/18/06, 01/02/07, 02/02/07, 03/06/07, 06/12/07, 06/21/07, 01/22/08, 02/04/08, 02/12/08, 04/29/08

Physical therapy notes, 2/23/06 to 3/9/06

MRI left knee, 12/28/06

MRI right knee, 12/28/06

DDE, Dr. 5/3/07

DDE, Dr. 1/2/08

Office notes, Dr. 6/10/08, 06/20/08, 07/03/08, 09/04/08

MRI right knee, 06/17/08

Peer reviews, 08/13/08, 08/21/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who fell on xx/xx/xx and injured both knees. The claimant treated with Dr. The exam of 01/24/06 documented marked discomfort and effusion both knees and tenderness over the patellofemoral joint. Patellar compression test was positive. There was marked joint line tenderness medially. McMurray's was positive for medial meniscus. Apley's test was positive. The left knee had a small bursa over the tibial tubercle with infrapatellar bursitis. X-rays were noted to show narrowing of the joint space over the medial compartment with pretty much bone on bone and moderate patellofemoral arthritis. The claimant was treated conservatively. The infrapatellar bursa left knee was aspirated on two occasions. In June and July 2006 left knee arthroscopy and removal of bursa was discussed.

The records lapsed until December 2006 at which time a left knee MRI on 12/28/06 showed a small effusion; three compartment osteoarthritis and chondromalacia patella. Cruciate and collateral ligaments and meniscus was intact. MRI of the right knee showed similar findings. On 01/02/07 Dr. noted that the claimant was unable to take any kind of NSAID because of upper GI problems and ulcer disease. A cortisone injection to the left knee was given on 02/02/07 with improvement for about two months. A second injection was given on 06/12/07 with no improvement. On 06/21/07 Dr. documented marked swelling over the left knee and some tenderness of the medial joint line. McMurray's was positive for medial meniscus and Apley's test was positive. Arthroscopic evaluation was again discussed.

A 01/02/08 Designated Doctor Evaluation with Dr. documented crepitus and fluid in the left knee. There was some patellar grinding suggestive of patellofemoral arthralgia and some clicking on McMurray test; however it was difficult to determine if it was medial meniscus or crepitus. Left knee range of motion was 0-110 degrees. The diagnosis was left knee infrapatellar bursitis and internal derangement and right knee degenerative joint disease.

The claimant continued to treat with Dr. with persistent left knee pain. On 02/04/08 the claimant was seen for increased right knee pain after missing a step. The right knee was aspirated and injected. The claimant continued to have left knee pain. In April 2008 she fell on her left knee with marked bruising over the infrapatellar tendon. McMurray testing continued to be positive. There was marked tenderness over the medial joint line, moderate swelling and range of motion 0-140 degrees. No x-rays were obtained.

The 06/10/08 visit noted that the claimant had fractured her right ankle a month earlier. MRI of the right knee on 06/17/08 showed a probable non displaced proximal right fibular fracture and posterolateral tibial contusion. The claimant at that time was treating with Dr. who also recommended arthroscopy of the left knee. At the 09/04/08 visit Dr. noted continued left knee pain and difficulty with flexion and extension. On exam there was tenderness of the medial joint line and pain on McMurray maneuver and some pain on compression of the patella against the femoral condyle. The diagnosis was medial meniscal tears bilaterally and arthroscopy of the left knee was recommended.

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

Clearly, this claimant has tricompartmental osteoarthritis. The most recent MRI did not reveal any pathology which would be amenable to arthroscopic treatment. There was specifically no clear evidence of meniscal tear. It would appear that this claimant has already been deemed maximally medically improved.

When one turns to the ODG criteria for arthroscopy, imaging findings are needed to include a meniscal tear on MRI. These would appear to be absent in this case.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Knee: Meniscectomy.

Recommended as indicated below for symptomatic meniscal tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings.

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) Arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical and medical therapy, according to the results of a single-center, RCT reported in the New England Journal of Medicine. The study, combined with other evidence, indicates that osteoarthritis of the knee (in the absence of a history and physical examination suggesting meniscal or other findings) is not an indication for arthroscopic surgery and indeed has been associated with inferior outcomes after arthroscopic knee surgery. However, osteoarthritis is not a contraindication to arthroscopic surgery, and arthroscopic surgery remains appropriate in patients with arthritis in specific situations in which osteoarthritis is not believed to be the primary cause of pain.

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.

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)**