CLAIMS EVAL

Utilization Review and
Peer Review Services

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 4-23-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right knee arthroscopy with lateral meniscectomy and chondroplasty

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

American Board of Orthopaedic Surgery-Board Certified

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MD., office visits from 9-25-07 through 12-17-07 (5 visits).
- 11-16-07 MRI of the right knee.
- 3-25-08, MD., performed a Required Medical Evaluation.
- DO., office visits from 5-14-08 through 9-18-08 (5 visits).
- 5-29-08 EMG/NCS of the lower extremities performed by, MD.
- Medical records reflect the claimant began a course of physical therapy on 7-1-08.
- 7-18-08, DC., performed a Designated Doctor Evaluation.
- MD., office visits from 7-23-08 through 1-16-09 (4 visits).
- 8-8-08 MRI of the right hip.
- 9-3-08 the claimant was provided with the first Orthovisc injection.
- 9-11-08 the claimant was provided with orthovisc injection #3.
- 9-23-08 MD., performed a Designated Doctor Evaluation.
- 10-13-08 evaluation for a work hardening program on 10-13-08.
- 11-12-08 MD., re-evaluated the claimant.
- 3-6-0 adverse determination was provided by MD.
- 3-26-09 Letter provided by.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 9-25-07, the claimant was evaluated by MD. This female was seen today for evaluation of pain in her right leg. She states she sustained an injury to her right leg on xx-xx-xx. She states on the previous xx, the xx, she was working as a for the school system when she caught her foot ion a grass runner and fell. She did not have any real problem at that time. However, the next two days she pulled up grass at her site. However, on, she was again working as a, caught her foot in a runner and fell on two occasions. She last time she could not get up without help because she had pain in her whole leg. She has been seen at since then and was treated with physical therapy. The

pain initially was posteriorly in her hip and down her leg and it was painful with sitting, but that has gotten better now. She is able to sit with comfort. She also has not been able to bend her knee since then. She states it is not secondary to pain; she just cannot bend it. Therapy has consisted of heat, massage and Tylenol. She denies any difficulty before, but she does admit that she has marked arthritis in her knee that she has had for a while. On exam, there is no tenderness in the ischial tuberosity, no tenderness over the greater trochanter. She has a good range of motion of her hip. She is slightly tender diffusely over the quad and hamstring. Examination of her knee reveals no tenderness, no effusion and no instability in extension. Attempting to evaluate her range of motion, she will not relax her quad. Even with a great deal of coaxing, the evaluator could flex it only about 30°. This is not painful; she just seems to voluntarily keep it rigid. X-ray of her right hip, femur and knee are taken. The hip is normal and femur is normal. X-rays of the knee reveals Grade IV changes in the medial compartment from a so-called end-stage degenerative osteoarthritis. This obviously pre-dated the injury of three weeks ago. The evaluator felt that her injury is primarily a contusion to the quad and hamstring and really all she needs is to continue with vigorous physical therapy. She needs a lot of wet heat and range of motion exercises. The evaluator discussed with her the necessity of bending her knee and trying to regain her motion. The evaluator felt this is all muscle soreness and certainly, it has no structural problem underlying it, other than her arthritis, which preexisted this.

Follow-up with Dr. on 10-16-07 notes the claimant had only attended physical therapy two times. Thee as some mix up in her paper work. The evaluator noted the claimant has end-stage degenerative osteoarthritis, and she does admit that she has had this for a long time and has even discussed a total knee replacement with doctors previously. She still has very limited motion in her knee. The evaluator felt it was imperative she have physical therapy, stretching and active/assistive range of motion to try to get her knee back. The evaluator informed the claimant that as far as surgery on her knee is concerned, the only surgery would be total arthroplasty and it could not be done unless she had motion in her knee.

Follow-up with Dr. on 11-6-07 notes she is better after therapy. She is still tight in her quad. The evaluator noted that he had a great deal of concern, passively bend her knee down about 45°. She has a lot of tightness in her quad and resists.
The evaluator reported that she is either going to have to work diligently to get her motion back or she is going to have a stiff leg for the rest of her life. Therefore, she is going to have to choose whether or not she wants to make it work. She is to continue in vigorous therapy, but needs to work diligently on it on her own at home.

On 11-16-07, an MRI of the right knee showed prominent degenerative change involving the knee, especially in the medial compartment. There are prominent degenerative tears and maceration involving the medial meniscus. Small to moderate joint effusion noted, in the knee joint. Questionable small parrot-beak type tear involving the posterior part of the lateral meniscus.

Follow-up visit with Dr. dated 11-20-07 notes the claimant's range of motion is about the same. She does admit when therapy works with her, she feels tightness in her thigh both anteriorly and posteriorly. She also admits that she knew four years ago that she was almost down bone on bone in her knee. The MRI was reviewed. She has obviously marked degenerative changes in the medial compartment of her knee. Soft tissue in the thigh and the knee otherwise appear to be normal. The evaluator reported that the MRI does not demonstrates anything that he did not already know and that is marked degenerative changes in her medial compartment of her knee. The evaluator again reiterated to her she needs to work on bending if and flexion multiple times every day; and until she makes it bend, it is not going to do any better.

On 12-17-07, the noted that she really has not changed much at all. Her range of motion is virtually the same. The evaluator noted that in spite of therapy, the problem is tight muscle and a worn-out knee. She needs to be scheduled for a MMI evaluation and close this.

On 3-25-08, MD., performed a Required Medical Evaluation. It was his opinion that the claimant had reached MMI on 12-17-07 and awarded the claimant 14% whole person impairment.

On 5-14-08, DO., evaluated the claimant. He noted the claimant has had some physical therapy. No one has addressed her hamstring or sciatic nerve pain in her right leg. The evaluator felt that MMI was premature. On exam, the claimant had decreased range of motion of the right knee, right knee effusion, positive Appley's test, positive Smiley's test, positive patellar grind. She had a swollen right ankle and right foot. The evaluator recommended physical therapy, EMG/NCS of the right leg, orthopedic consultation, pain management consultation, prescription for Tramadol and Lyrica.

On 5-29-08, an EMG/NCS of the lower extremities performed by MD., was within normal limits.

Follow-up with Dr. notes the claimant has not been in physical therapy. She has not had an orthopedic or neurological consultation. The evaluator recommended physical therapy as soon as possible and pain management.

Medical records reflect the claimant began a course of physical therapy on 7-1-08.

On 7-18-08 DC., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated MMI in twelve weeks. The evaluator recommended the claimant be evaluated by an orthopedic surgeon.

On 7-23-08, the claimant was evaluated by MD. The evaluator reported the claimant had an EMG/NCS on 5-29-08, which showed no derangement or electrodiagnostic evidence of neuropathy or plexopathy. The claimant reported diffuse stiffness of the right lower extremity and upper leg. The claimant was unable to fully flex the knee. Exam of the knee shows diffuse swelling throughout the entire right knee joint.

Otherwise, no discoloration, redness or warmth. The claimant has substantially decreased range of motion from -6 to 22 degrees with guarding. No tenderness or crepitation is noted. Patella tracking is unremarkable and no tilting is noted. There is positive grinding test. Negative apprehension test. There is positive pain to varus arid valgus stress testing, Negative anterior and posterior drawers but she is tender with these motions. It is difficult to get her into proper positioning for the anterior and posterior drawers. Lachman's could not be completely evaluated. Negative pivot-shift, Positive McMurray's. Positive Apley's. Distal neurovascular status remains intact. There are mild signs of tortuous veins diffusely throughout the right knee joint. Exam of the right hip shows the claimant's pelvis is level. No abnormal fullness or deformity is noted. Skin overlying the groin and inguinal regions show no discoloration, redness, warmth or any other lesion. Range of motion of the hip is full and painless. No flexion contracture is noted. Faber and Patrick tests are negative. Distal neurovascular status is intact. Tender to palpation at the trochanteric bursa with positive antalgic gait. Impression: Right knee pain, swelling, medial meniscal tearing, lateral meniscal tearing with parrot beak type tear, chondromalacia patella, loose body formation, synovial hypertrophy, osteochondral defect and post traumatic arthritic changes, right hip pain, mild swelling, posttraumatic arthritic changes of right hip with right hip trochanteric bursitis. The claimant was provided with a prescription for Celebrex, Ultracet and Medrol Dosepack. The claimant was continued with physical therapy. The claimant was referred for her heart disease and blood pressure treatment. The evaluator recommended a medical and lateral meniscectomy, chondroplasty and removal of loose body or synovectomy.

Follow-up with Dr. dated 7-25-08 notes the claimant continues with some pain in her hamstring area with some stiffness and she is unable to bend her knee. The evaluator reported the claimant has exhausted all physical therapy visits. Her EMG/NCS was normal. The claimant is referred for pain management as soon as possible. The claimant is to continue with medications.

An MRI of the right hip dated 8-8-08 notes mild degenerative changes in the hips bilaterally. No bony destructive lesions indentified. No fracture identified. There is a tiny right hip joint effusion.

Follow-up with Dr. dated 8-11-08 notes the claimant was denied surgery and to be treated conservatively. Therefore, the evaluator recommended medications, physical therapy and injections. The evaluator recommended Orthovisc Viscosupplementation. The claimant was continued with her medications and with physical therapy with Dr.

On 8-22-08, Dr. reevaluated he claimant. The evaluator felt the claimant would be an excellent candidate for a work hardening program.

The claimant was again evaluated by Dr. on 8-25-08. The claimant is on Ultracet and Celebrex. A series of Orthovisc has been approved.

On 9-3-08, the claimant was provided with the first Orthovisc injection.

Follow-up visit with Dr. on 9-11-08 notes the claimant was provided with orthovisc injection #3.

Follow-up with Dr. dated 9-15-08 notes the claimant continues with pain in her hamstring area with some stiffness and is unable to end her knee. The claimant was placed on light duty with restrictions. The evaluator noted the claimant was pending pain management. The claimant was continued with her medications.

On 9-23-08, MD., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 11-23-08 as the date of MMI. The evaluator recommended the claimant continue with a home exercise program and as recommended by the orthopedic surgeon evaluation in 60 days for possible surgery.

Medical records reflect the claimant was evaluated for a work hardening program on 10-13-08.

On 11-10-08, the claimant was evaluated by Dr.. The claimant continues with some weakness in her right knee, but she is feeling better and doing a little better. She still has an antalgic gait. The evaluator noted the claimant is still pending a work hardening program. The claimant is to continue to follow-up with Dr. for surgical evaluation. The claimant is continued on Tramadol, Lyrica and Celebrex.

On 11-12-08, MD., re-evaluated the claimant. He certified the claimant had not reached MMI and estimated 2-12-09 as the date of MMI. The evaluator noted the claimant has another hearing on 12-11-08 and follow by orthopedic surgeon. The evaluator noted he would look at the final judge ruling.

On 1-16-09, the claimant was evaluated by Dr. The evaluator reported that the claimant was a suitable surgical candidate. Therefore, she should proceed with the medial and lateral meniscectomy and chondroplasty. The claimant needed preoperative clearance and postoperative physical therapy.

On 3-6-09, an adverse determination was provided by MD. The evaluator noted that a Peer to Peer was performed with PA, as Dr. was not available to discuss the case. It was noted that a CCH was held on 10-9-08 notes that the compensable injury of 8-31-07 included a medial meniscus tear and lateral meniscus tear of the right knee and chondromalacia of the right patella. The evaluator reported that arthroscopic and meniscus surgery will not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis. The meniscectomy will not improve the osteoarthritis. Arthroscopic surgery for knee osteoarthritis offers no added benefit to optimize physical and medical therapy.

3-26-09 Letter provided by to request reconsideration for the requested surgery.

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

ARTHROSCOPY WITH PARTIAL MEDIAL MENISCECTOMY AND CHONDROPLASTY HAS A HIGH PROBABILITY OF FAILURE. MULTIPLE FACTORS INDICATE A LIKELY POOR OUTCOME. CLAIMANT WOULD LIKELY HAVE A FAIR TO POOR OUT COME FROM A TOTAL KNEE ARTHROPLASTY.

THE MRI FINDINGS OF THE KNEE SHOW PRE-EXISTING CHANGES OF THE KNEE WITH SEVERE MEDIAL COMPARTMENT ARTHRITIS AND DEGENERATIVE CHANGES AND MACERATION OF THE MENISCUS. THESE FINDINGS ARE NOT THE RESULT OF THE MULTIPLE FALLS. THEREFORE, THE REQUEST FOR ARTHROSCOPY WITH PARTIAL MEDIAL MENISCECTOMY AND CHONDROPLASTY IS NOT CERTIFIED.

ODG-TWC, last update 4-21-09 Occupational Disorders of the Knee – Meniscectomy: Recommended as indicated below for symptomatic meniscal tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings. (Kirkley, 2008) 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 mensicectomy may have better long-term results than a subtotal mensicectomy for a degenerative tear. (Englund, 2001) Another study concludes that partial mensicectomy 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 mensicectomy. (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 mensicectomy. Arthroscopy and meniscus surgery will not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis, and mensicectomy will not improve the OA.** Meniscal repair is much more complicated than meniscal excision (mensicectomy). Some surgeons state in an operative report that they performed a meniscal repair when they may really mean a mensicectomy. 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 mensicectomy 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) **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. (Kirkley, 2008)** Asymptomatic meniscal tears are common in older adults, based on studying MRI scans of the right knee of 991 randomly selected, ambulatory subjects. Incidental meniscal findings on MRI of the knee are common in the general population and increase with increasing age. Identifying a tear in a person with knee pain does not mean that the tear is the cause of the pain. (Englund, 2008) Arthroscopic meniscal repair results in good clinical and anatomic outcomes. (Pujol, 2008) Whether or not meniscal surgery is performed, meniscal tears in the knee increase the risk of developing osteoarthritis in middle age and elderly patients, and individuals with meniscal tear were 5.7 times more likely to develop knee osteoarthritis. (Englund, 2009)

ODG Indications for Surgery™ -- Meniscectomy:

Criteria for mensicectomy or meniscus repair (Suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positve):

1. Conservative Care: (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. PLUS
2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of give 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.

(Washington, 2003)

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)