

## Notice of Independent Review Decision

### **DATE OF REVIEW:**

08/12/2009

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Knee surgery (right knee); partial medial and lateral meniscectomies.

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

Board Certified Orthopaedic Surgeon

### **REVIEW OUTCOME**

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

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.

**The requested knee surgery (right knee) partial medial and lateral meniscectomies is not medically necessary.**

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- referral form
- 07/31/09 Referral
- 07/30/09 Notice To Utilization Review Agent Of Assignment, ,
- 07/30/09 Notice To , LLC Of Case Assignment, ,
- 07/30/09 Confirmation Of Receipt Of A Request For A Review,
- 07/29/09 Request For A Review By An Independent Review Organization
- 07/21/09 Review Summary letter, , M.D.,
- 06/30/09 Notification of Determination letter, , M.D.,
- 06/17/09 Precert Request,
- 10/17/07 to 06/11/09 chart notes, ., M.D.,
- 06/01/09 MRI lower extremity joint,
- 10/23/07 Operative Report, , M.D.,
- 10/16/07 chart note, , M.D.,
- Note: Carrier did not supply ODG Guidelines.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured individual is a xx year old morbidly obese (6'1"-320 lbs.) male who was reported to have sustained a comminuted right patella fracture and minimally displaced right radial neck fracture in a work-related fall on xx/xx/xx. He was initially seen by M.D. who referred the patient to M.D. for operative fixation of the patella fracture. Dr. performed an open reduction and internal fixation of the patella fracture on 10/23/2007 and treated the radial neck fracture non-operatively. The injured individual was then seen at various times for postoperative followup and was reported to be doing well. Dr. noted a normal examination in his note dated 03/17/2008 and recommended the injured individual be setup for maximum medical improvement (MMI). He reported the fracture to be healed and discharged the injured individual to as needed. There is a 14 month gap (03/17/2008-05/18/2009) and the injured individual now represents complaining of medial sided knee pain. Dr. reported medial joint line tenderness and a positive McMurray's. He ordered a MRI which was performed on 06/01/2009 which was reported to show horizontal type tears of the lateral and medial menisci. His office visit of 06/11/2009 now noted medial and lateral joint line tenderness and a positive McMurray's. He then submitted the request for the proposed surgical procedures. There is no other indication of any additional treatment recommended.

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

The injured individual is a morbidly obese male with the significant co-morbidities of hypertension and diabetes. He is now over 22 months status post the initial injury. There is no mention of any meniscus injury at the time of the initial surgery in the dictated operative report since this was an open procedure. The injured individual was reported to have done well following the operative fixation of the patella fracture and was discharged to an as needed basis on 03/17/2008. He then returned 14 months later with medial sided knee complaints. Dr. noted in his original evaluation of 10/16/2007 a prior history of right knee surgery. There is no documentation of any conservative treatment by Dr. . There is no effusion or locking documented.

Official Disability Guidelines:

Indications for Surgery -- Meniscectomy:

Criteria for meniscectomy 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 positive):

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)

The injured individual does not satisfy the above criteria upon review.

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 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) 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)

There is no information regarding an adequate trial of conservative treatment. The injured individual was doing well and discharged on 03/17/2008. Current symptoms appear more likely a result of age and his morbid obesity.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**  
**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**