

# P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/11/09

**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 Surgery, 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**

Right knee EUA diagnostic arthroscopy with meniscal debridement versus repair

### **REVIEW OUTCOME**

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

Overtuned (Disagree)

### **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 xx/xx/xx Hospital ER consultation rpt from Dr.
- o 09-14-08 Lab reports, 3 pp
- o 10-02-08 Final imaging reports, 17 pages
- o 10-03-08 Physician progress record, signature illegible
- o 10-04-08 Hospital records with notes and radiographic rpts, 10 pages
- o 10-06-08 Physician noted PA-C
- o xx/xx/xx Employers First Report of Injury from Dr.
- o 10-13-08 Orthopedic clinic note from Dr.
- o 10-16-08 Assessment, PT
- o 10-20-09 E-mail request for UR - PT x 12, unsigned
- o 10-21-08 Case Summary Report from LPN
- o 10-21-08 Progress note from Dr.
- o 10-21-08 Patient History Form from Dr.
- o 10-22-08 Case Summary Report from LPN
- o 11-03-08 Progress note from PT
- o 11-06-08 Knee examination report from Dr.
- o 11-06-08 Progress note from PT
- o 12-15-08 Progress note from PT
- o 12-18-08 Orthopedic note from Dr.
- o 12-19-08 Progress noted from PT
- o 12-24-08 Case Summary Report from LPN
- o 01-27-09 PT note from PT

- o 01-29-09 Script for Dynamic Ext brace from Dr.
- o 02-04-09 Utilization review authorization for PT x 12 from
- o 02-06-09 Case Summary report from LPN
- o 02-09-09 Clinic notes from PA-C
- o 02-11-09 PT note from PT
- o 02-13-09 Clinic notes from PA-C
- o 02-29-09 Scheduling notice for knee scope/lysis from Dr.
- o 03-29-09 Orthopedic note from Dr. recommending MUA
- o 03-31-09 Preauthorization request for MUA from Dr.
- o 04-03-09 Authorization for MUA from
- o 04-14-09 Anesthesia record from Dr.
- o 04-14-09 MUA procedure report from Dr.
- o 04-22-09 PT note from PT
- o 04-23-09 Order for PT from Dr.
- o 04-23-09 Orthopedic report from Dr.
- o 04-24-09 PT note from PT
- o 04-27-09 Case Summary Report from, LPN
- o 04-28-09 Physician record - Rt knee 1 p, unsigned
- o 04-29-09 Authorization for PT x 12 from
- o 05-11-09 PT notes from PT 3 pp.
- o 05-15-09 Radiograph report right ankle, unsigned
- o 05-15-09 Medical report from Dr.
- o 05-28-09 Orthopedic report from Dr.
- o 06-03-09 Review for manual wheelchair from
- o 06-04-09 Adverse determination letter for manual wheelchair
- o 07-15-09 MRI right knee read by Dr.
- o 07-20-09 Medical report from Dr.
- o 07-24-09 Medical report from Dr.
- o 08-12-09 Medical report from Dr.
- o 08-25-09 Clinic notes from Dr., date somewhat illegible 2 pp
- o 09-08-09 Orthopedic report from Dr. with also 3 pp progress notes
- o 09-23-09 Case Summary Report from LPN
- o 09-23-09 Approval for 6 sessions PT (63+6)
- o 10-19-09 Case Summary Report from LPN
- o 10-20-09 Progress notes from PT
- o 10-21-09 Case Summary report from LPN
- o 10-21-09 Fax - preauthorization request from Dr.
- o 10-26-09 Initial review for meniscal repair
- o 10-26-09 Initial Adverse Determination Letter
- o 10-29-09 Progress note from Hospital - Dr.
- o 11-03-09 Review on reconsideration
- o 11-03-09 Adverse Determination letter from on reconsideration
- o 11-10-09 Request for IRO from the provider
- o 11-23-09 Confirmation of receipt of request for IRO from TDI
- o 11-24-09 Notice of IRO assignment from TDI

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

According to the medical records and prior reviews the patient is a male who sustained an industrial injury to the arm, leg and right knee on xx/xx/xx associated with a fall of about 20-25 feet. He was working on a bucket when it was knocked down. He fell with the bucket. A puncture wound of the right arm was noted. Imaging showed normal head, chest, pelvic, cervical spine, clavicle, ankle, foot, and arm studies. However, a fracture was found through the proximal third of the right fibula, without tibial fracture.

MRI of October 3, 2008 was given impression of evidence of a bone contusion in the lateral right femoral condyle at the posterior aspect of the right lateral tibial plateau (suggestive of a compression fracture) and in the right fibular head. There is a complete posterior and anterior cruciate ligament tear and a bucket handle tear of the medial (findings state lateral) meniscus. There is probable meniscocapsular separation is noted adjacent to the posterior aspect of the posterior horn of the medial meniscus. A large joint effusion is present and there is a tibial collateral ligament tear. There is fibular collateral ligament sprain and extensive edema around the knee. Findings state there is suggestion of "bucket handle" tear of the lateral meniscus and no evidence for medial meniscal tear.

At orthopedic evaluation on October 13, 2008, the patient was found to have concerns of a proximal third fibular fracture. He was found to have a KD-IV ligamentous injury of his knee. He was placed in a knee brace locked at 0 and given crutches. He also had lacerations to his right leg and a puncture wound to his right arm. There is MRI evidence of complete rupture of the ACL, PCL, bucket handle tear of the medial meniscus and adjacent posterior horn of the medial meniscus. He will never have a normal and natural knee. He may require a very extensive multi-ligamentous reconstruction.

The patient initiated gentle physical rehabilitation exercises on October 16, 2008. He was wearing a brace at that time. Per a nurse note, ODG supports 30 visits of PT for the patient's diagnosis. (He has since completed approximately 69 visits of PT.)

On November 3, 2008 knee flexion was to 82 degrees and extension to 18 degrees. Orthopedic evaluation of November 6, 2008 noted range of motions is still a significant problem. On December 12, 2008 knee flexion had been improved to 99 degrees. There is concern for his ankle motion. At this time surgery is no longer being considered in regard to the ligaments.

By December 24, 2008 the patient had completed 24 sessions of PT. Knee extension was 99 degrees and extension was lacking 18 degrees. He missed some sessions and regressed a bit. Per the orthopedic report of January 28, 2009 he was noted to have made very little real progress since December and is not doing much on his own. He continues to use his hinged knee brace and walker. He is at a plateau and manipulation under anesthesia was recommended. A dynamic brace would be attempted first.

At orthopedic reassessment on March 23, 2009 the patient was still anticipating MUA. His best effort at flexion was 100 degrees and he was lacking 25-30 degrees on extension. The lack of extension is affecting his gait pattern. MUA was anticipated to improve his motion by at least 50%. MUA was performed on April 14, 2009. Arthrofibrosis had set in and he was lacking 30 degrees of extension. Under anesthesia, he could be brought to about -10 degrees of extension. Aggressive PT followed MUA and continuation of dynamic splinting, but by orthopedic reassessment of April 23, 2009 it looked like he was reaching a plateau stage and was recommended to think about retraining and permanent and stationary status. Per the therapist on April 24, 2009 he uses a Canadian crutch, has a shortened stride and has a limp. On April 28, 2009 the evaluator notes his knee was still swollen.

In May 2009 the therapist notes the patient cannot even dorsiflex his ankle to 90 degrees. He is working harder at home however on knee motion. An ankle x-ray of May 15, 2009 noted periarticular osteoporosis involving the talus, tibia, calcaneus and tarsal bones. Reflex sympathetic dystrophy was suspected. On May 28, 2009 knee flexion was lacking 5 degrees of extension and flexion was to 80-90 degrees. An open arthroscopic release was mentioned as one possible plan. He will continue dynamic splinting and PT. Pt was not recommended in review as no recent improvement had been documented. Request for a manual wheelchair was also denied as he was known to be walking.

Updated MRI of the right knee was performed on July 15, 2009 and provided impression: Thinning of the articular cartilage in both the medial and lateral joint compartments with a small amount of bone marrow edema in both the medial femoral condyle and medial tibial plateau. Marked blunting of the anterior horn of the lateral meniscus consistent with tear. Probable oblique tear posterior horn lateral meniscus. Poor definition of the femoral attachment of the ACL suspicious for chronic tear. Chondromalacia involving both medial and lateral patellar facets.

The patient was seen in follow-up by a joint replacement/arthroscopic surgery specialist on July 20, 2009. RSD was initially suspected at the right ankle. The knee diagnosis was not clear but a differential diagnosis was made of ACL tear, as there was a positive Lachman's test and interarticular pathology was suspected. There is thinning of the cartilage and bone marrow edema which is causing some of the pain. Thirdly, there is a meniscal pathology of the lateral meniscus, consistent with a tear, and there is also chondromalacia, involving both the medial and lateral facets. In sum, there is an ACL tear, cartilage thinning and bone marrow edema and probable oblique tear of the posterior horn of the lateral meniscus causing some of the right knee symptoms. The right ankle diagnosis has been confirmed of reflex sympathetic dystrophy. Recommendation is for arthroscopic examination of the knee, reconstruction of the ACL, and also lateral meniscectomy. Per a July 24, 2009 report, the MRI was subsequently made available which showed also a complete tear of the posterior cruciate ligament and a bucket handle tear of the medial meniscus. As this specialist does not repair the posterior cruciate ligament in his surgeries, the patient is referred to another specialist to consider a right knee surgery.

A specialty consultation took place on August 12, 2009. The MRI findings of October 3, 2008 and July 15, 2009 were reviewed. He can ambulate with some difficulty without use of a support. With use of a single crutch he does much better. He has an extension lag of 15 degrees at the right knee. There is flexion to 90 degrees but no further. He has obvious posterior cruciate ligament instability. He needs to be seen for multiple ligament reconstruction. However, this specialist also does not perform posterior cruciate ligament reconstruction and a third specialist is recommended.

A specialty consultation was provided on September 8, 2009. The patient was previously diagnosed with a KD-IV right knee dislocation. He has pain and stiffness despite MUA in April 2009. The patient states, despite PT, which has now stopped, he cannot get any more motion in the knee. His brace does not fit very well so he is getting by with a crutch or cane. He is using hydrocodone. He is 5' 4" and 140 pounds. Range of motion of the knee is very poor, active 15-85 degrees and passive 10-90 degrees. The collateral ligaments are stable. The PCL is 1-2+ and the ACL is trace to 1+ in terms of stress. He was informed that if he has surgery now his knee will be stiffer. Recommendation was for arthroscopy with debridement and whatever else could be done in terms of cartilage and lateral meniscal damage. He opted for surgery. He is recommended PT in the meantime so he does not get stiffer.

Per PT assessment of October 20, 2009 right knee flexion is to 105 degrees and extension -2 degrees (normal). Ankle dorsiflexion is 86/99. There is edema at the suprapatellar area of 1+ and muscle damage/atrophy at the right calf.

Request for diagnostic arthroscopy of the right knee with meniscal repair was considered in review on October 26, 2009 with recommendation for non-certification. 52 pages of records were reviewed. A peer discussion was attempted but not realized.

The incident of injury and MRI is reviewed. Per a clinic note of December 18, 2008, the patient feels his knee is improving and he has been in PT. He is wearing a hinged knee brace and is using a walker. Examination reveals no significant swelling. There is decreased ROM in the ankle with moderate quadriceps atrophy. Lachman's is mildly positive. The patient was recommended to continue PT and start weightbearing activities. Clinic note of January 21, 2009 notes the patient has been in PT and has 25 degrees of extension lag with 95 degrees of flexion without laxity on testing. The patient was placed in a dynamic extension brace but does not demonstrate much progress with this treatment - He still demonstrates 30 degrees of extension lag with 100 degrees of flexion. He apparently appears to have been provided MUA and returned to therapy. During therapy he can achieve a 10 degree extension lag and only has a deficit of 30 degrees on flexion. Exam of April 23, 2009 notes continued extension of 20 degrees with 100 degrees of flexion. Another MRI was recommended. On May 28, 2009 he has made some improvements with ROM with extension lag to 5 degrees and 90 degrees of flexion. Moderate quadriceps atrophy is noted. There is no instability. On September 8, 2009 he continues to have poor range of motion in the right knee to 90 degrees with flexion with 10 degree extension lag. Rationale for non-certification is lack of an updated MRI as recommended by the provider. ODG does not recommend meniscal surgery without a recent MRI study.

Request for reconsideration right knee diagnostic arthroscopy with meniscal repair was considered in review on November 3, 2009 with recommendation for non-certification. A peer discussion was attempted but not realized. The mechanism of injury is unknown. Active ROM is 50-85 degrees, passive is 10-90 degrees. PCL is +1 to 2. ACL was trace to 1+ and moderate quadriceps atrophy noted. He requires crutches to ambulate secondary to splinting. He has had 63 physical therapy visits and Dynasplint treatment as well as manipulation under anesthesia on April 13, 2009. Diagnosis is closed fracture of the tibia/fibula. Rationale for non-certification states the provider has failed to provide any objective documentation for the need for meniscal repair. The claimant is not documented to have popping, positive McMurray's or joint line tenderness and there is no imaging to document the need for meniscal repair.

On November 10, 2009 request was made for an IRO.

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

The patient has traumatic dislocation and multiligamentous injury and early arthrofibrosis of the right knee. Imaging has shown, suggestion of "bucket handle" tear of the lateral meniscus and no evidence for medial meniscal tear (October 2008) and marked blunting of the anterior horn of the lateral meniscus consistent with tear. Probable oblique tear posterior horn lateral meniscus (July 2009). Despite approximately 65 visits of PT, 15 visits since MUA of April 2009, right knee range of motions remains poor. He also has possible RSD at the right ankle.

The first line reviewer recommended non-certification with rationale that an updated MRI as recommended by the provider was not available. This reviewer consistently referred to the patient as a female. The second line reviewer recommended non-certification with similar rationale: The provider has failed to provide any objective documentation for the need for meniscal repair. The claimant is not documented to have popping, positive McMurray's or joint line tenderness and there is no imaging to document the need for meniscal repair.

ODG criteria for meniscal 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.

Current recommendation is for arthroscopy with debridement and whatever else can be done in terms of cartilage and lateral meniscal damage. That there is damage to the meniscus per updated imaging is clear. Joint pain and swelling have been noted. There is limited range of motion. Additionally there is need for other repairs in the arthroscopy, meniscal debridement and/or repair appears to be a secondary issue. Given the failure of PT, Dynasplint, HEP, medication and the degree of persisting disability, arthroscopic evaluation with repairs as needed is a reasonable medical option. It is also noted that no other treatment options appear to be available and if the patient continues to rely on crutches, secondary and more costly physical conditions are likely to result.

Therefore, my recommendation is to disagree with the previous non-certification for right knee EUA diagnostic arthroscopy with meniscal debridement versus repair.

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 - Knee and Leg Chapter (11-27-2009) Meniscectomy:

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

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.

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. 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.

Most meniscus tears cannot be treated by a repair.

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 (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.