



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 11-9-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left knee scope 29880

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

- 4-9-04 Surgery to the left knee.
- 8-12-04 Surgery to the left knee.
- 1-20-05 MRI of the left knee.
- 6-16-05 Surgery to the left knee.
- 11-29-05 MRI of the left knee.
- 4-5-06 Surgery to the left knee.
- 9-21-06 MRI of the left knee.
- 11-22-06 Surgery to the left knee.
- 11-9-07 MRI of the left knee.
- 11-19-08 MD., office visit.
- MD., office visits from 12-30-08 through 9-22-09.
- 8-3-09 MD., office visit.
- 9-17-09 MRI of the left knee.
- 9-29-09, MD., performed a Utilization Review.
- 10-15-09 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 4-9-04, the claimant underwent left knee arthroscopy for a diagnosis of tear of medial meniscus of the left knee and infrapatellar synovial plica.

On 8-12-04, the claimant underwent left knee arthroscopy with arthroscopic partial medial meniscectomy.

MRI of the left knee dated 1-20-05 showed status post partial resection of the medial aspect of the medial meniscus. Tear in the area of the resection of the medial meniscus in the medial and superior to the respected portion of the medial meniscus. Synovial effusion of the knee estimated between 7 and 10 cc of fluid.

On 6-16-05, the claimant underwent arthroscopic medial meniscectomy.

MRI of the left knee dated 11-29-05 showed a complex tear involving the body and posterior horn of the medial meniscus seen. A discoid lateral meniscus is identified with no acute tear. There is a mild joint effusion present. No ligamentous disruption seen. There is mild degenerative joint disease of the medial compartment of the femorotibial joint is identified.

On 4-5-06, the claimant underwent medial meniscectomy for a diagnosis of medial tear and chondromalacia of the patella, plus delaminating of the patella with a blister and also status post medial meniscectomy redo.

MRI of the left knee dated 9-21-06 shows a horizontal cleavage tear through the posterior horn and body of the medial meniscus seen communicating with the tibial surface. A discoid lateral meniscus is noted without acute tear. A mild joint effusion is present. Moderate degenerative joint disease of the medial compartment of the femorotibial joint is noted with no occult fracture.

On 11-22-06, the claimant underwent left medial meniscectomy.

11-9-07 MRI of the left knee shows a partial medial meniscectomy that has been performed. The posterior horn of the medial meniscus reveals no acute tear. The lateral meniscus is discoid in configuration without tear. A mild joint effusion is noted. O ligamentous disruption is seen. Mild narrowing medial compartment femorotibial joint with no occult fracture.

On 11-19-08, the claimant was evaluated by MD. The claimant is seen for followup of her right shoulder. The evaluator recommended glucosamine and chondroitin sulfate and Celebrex.

On 12-30-08, the claimant was evaluated by MD. The claimant had a work injury when she slipped and hurt her right shoulder and left knee. She is not attending physical therapy. The claimant had an MRI performed on February 2008 which showed a tear to posterior horn and body of the medial meniscus which communicates with the tibial surface. The left knee is swollen. She also complains of pain to the right shoulder. She has had five knee surgeries and one surgery on the left shoulder. On exam, the claimant has pain to the left knee with flexion. Extension is 0 degrees and flexion is 90

degrees. There are no neurological changes seen. The claimant has a positive McMurray's sign. The claimant was referred to Dr. for orthopedic followup. The claimant is to return to physical therapy. The claimant is provided with a prescription for Lidoderm patches, Vicodin, Flexeril, Lexapro and Advil.

Followup with Dr. on 3-17-09 notes the claimant complains of left knee pain. The evaluator recommended a chronic pain management program. The claimant has positive McMurray's sign. The claimant is continued with her medications.

Followup with Dr. dated 4-21-09 notes the claimant is not attending physical therapy. Her appointment with Dr. is due. The claimant has a positive McMurray's test. The claimant is continued with her medications and was referred with a chronic pain management program.

Followup with Dr. dated 5-26-09 notes the claimant is not attending physical therapy. She is continued with medications. The claimant is referred to Dr. and for a pain management program.

Followup with Dr. on 6-30-09 notes the claimant is continued with her medications. The claimant is referred to physical therapy and to Dr.

On 8-3-09, the claimant was evaluated by MD. The claimant reported left knee pain since a work injury on xx/xx/xx. The claimant has had multiple arthroscopic surgeries but continues to have pain. On exam, range of motion is 0-98 degrees. There is mild joint line tenderness, minimal lateral tenderness, positive grind, and positive tenderness over the patellar tendon. There was no ligamentous laxity. The claimant has positive McMurray's test. The evaluator felt the claimant had internal derangement of the knee, patellar tendon and patella. The evaluator felt that the claimant's troubles were due to an occult medial meniscal tear based on medial joint line tenderness. The evaluator recommended a prescription for Mobic, physical therapy. If no improvement, consider a new MRI and arthroscopy.

MRI of the left knee dated 9-17-09 showed extensive tears and shredding of the medial meniscus with increased in severity from the comparison report. Increasing osteoporotic change and joint space loss of the medial compartment, joint effusion and discoid lateral meniscus.

Followup with Dr. on 9-22-09 notes the claimant complains of left knee pain. The evaluator recommended the claimant followup with Dr. and provided the claimant with a prescription for Lidoderm patches and Vicodin.

On 9-29-09, MD., performed a Utilization Review. It was his opinion that the claimant complains of left knee pain, a well-healed scar on the left knee from the previous laser surgery was noted and positive McMurray's sign. The MRI scan finding of extensive tears and shredding of the medial meniscus with increasing in severity. The records indicate that the patient has not been attending her PT. There is no documentation

provided with regard to the failure of the patient to respond to conservative measures such as evidence-based exercise program and medications prior to the proposed procedure. Based on the submitted clinical record, the medical necessity for the request is not well established.

On 10-15-09, MD., performed a Utilization Review. The evaluator noted that the requested left knee arthroscopy is not medically necessary based on review of this medical record. This claimant has had five previous left knee arthroscopies, and in each one a partial medial meniscectomy was done. While the new MRI of 09/21/09 may show abnormality of the medial meniscus, this is an area that has been operated on five times, and so there is no way to determine whether or not this is in fact a new or ongoing problem. There is no documentation in the medical record of recurrent effusion or other positive physical findings. There is no documentation of conservative care with anti-inflammatory medication, activity modification, or cortisone injection. While this claimant may in fact have an abnormal MRI showing some changes of the medial meniscus, this area has been operated on five times, and so no one would ever expect this to be a normal MRI. Without evidence of mechanical symptoms or objective positive physical findings or failure of conservative care, this surgical request would not be medically necessary.

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

Based on review of the available medical records and MRI reports, my analysis would recommend against any further arthroscopic surgery with medial meniscectomy of the left knee.

Recent MRI studies have noted medical compartment changes with degenerative post surgical meniscal changes. Evidence based medical literature has recommended against surgery of the knee with osteoarthritis and degenerative meniscal tears.

Claimant has not been provided other options for management of the chronic knee pain. Therefore, the medical necessity for Outpatient left knee scope 29880 is not reasonable or medically necessary.

Per the ODG 2009 regarding meniscectomy: 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)

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)