

# P&S Network, Inc.

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## Notice of Independent Review Decision

### MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** 07/19/2010    **Amended:** 08-04-10

**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 Doctor, 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**

Left knee arthroscopy partial meniscectomy plus/minus lateral release

**REVIEW OUTCOME**

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

Overturned                      (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 06-10-09 Knee MRI read by Dr.
- o 06-11-09 Orthopedic report from, PA
- o 07-29-09 Orthopedic report from, PA
- o 07-30-09 PT note from , PT
- o 08-20-09 Orthopedic report from Dr.
- o 08-21-09 Request for preauthorization - surgery on 9-4-09 - from Dr.
- o 11-25-09 Orthopedic report from Dr.
- o 12-23-09 Fax request for preauthorization for surgery on 1-11-10, from Dr.
- o 12-30-09 Adverse Determination Letter from
- o 01-26-10 Reconsideration - Adverse Determination Letter from
- o 0x-03-10 Fax cover appeal from unsigned
- o 01-14-10 Request for IRO from the Claimant
- o 07-07-10 Fax note from regarding prior sending of IRO info
- o 07-08-10 Confirmation of Receipt of Request for IRO from TDI
- o 07-08-10 Notice to P&S of Case Assignment from TDI
- o 09-24-10 Orthopedic note, unsigned

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the left knee on xx/xx/xx when stepping off a ladder. MRI performed June 10, 2009 was given impression: No evidence of internal derangement, small joint effusion seen. Small Baker's cyst present. The findings state, lateral meniscus unremarkable; medial meniscus unremarkable; fartilage grossly unremarkable.

The patient was seen in orthopedics by the physician assistant on June 11, 2009. She brings her MRI report. There is no evidence of internal derangement. Her physician looked at the films and believes she probably has more protrusion of her meniscus with maybe a small degenerative tear. He recommended an unloader brace and some PT. She will be set up for some PT and return in 4-6 weeks.

The patient was seen in orthopedic follow up on July 29, 2009. She has completed PT. She has not really had any significant improvement. PT has not helped her knee. MRI was negative other than what her provider interpreted as a meniscal tear. She was placed in an unloader brace, but returns wearing the brace reporting no improvement. No effusion is seen at the knee. Impression is knee pain. She asked if she should go to PT this date and was told - if there is no significant improvement with the therapy she has been doing, she probably could just discontinue therapy at this point in time.

Physical therapy noted dated July 30, 2009 indicated the patient was initially assessed on June 24, 2009 and was discharged on July 30, 2009. The patient was not seen for follow-up appointments. At this time goals are unable to be assessed. She is discharged from PT unless further orders are seen.

The patient was provided an orthopedic examination on August 20, 2009. She was working in a. She twisted her knee getting off a ladder. She used crutches for a few days. She now has to markedly limit her activities. She does not smoke. She has gained some weight as she cannot walk like she normally does. There is no effusion at the left knee and range of motion is full. Lachman's and pivot test are negative. There is medial joint line tenderness. There is a positive McMurray. There is some tenderness over the medial patellar facet and lateral patellar facet. Her patella cannot be everted to a neutral position. X-rays show some mild DJD. MRI is read as no internal derangement by the radiologist. I think she does have a small undersurface medial meniscus tear and probable patellofemoral compression issues. Partial meniscectomy plus/minus lateral relief was discussed as she has not been improved with 4 months of conservative treatment.

Orthopedic note dated September 24, 2009 noted the patient was scheduled for arthroscopic surgery of the knee, but apparently the carrier was not going to cover the surgery as they felt the findings are chronic. The physician disagrees with this opinion...(copy missing).

The patient was examined by her physician on November 25, 2009. She saw an independent doctor several weeks prior for opinions regarding the recommended but denied knee surgery. He agrees with the diagnosis of medial meniscus tear and patellofemoral issues by their report and said he though surgery was indicated, so she has returned. There is no effusion at the left knee and there is good range of motion. There is no mediolateral instability. Lachman and pivot test are negative. There is medial joint line tenderness and a positive McMurray's. The lateral retinaculum is very tight. Impression is torn medial meniscus and patellofemoral issues.

Request for left knee arthroscopy partial meniscectomy plus/minus lateral release was considered in review on December 30, 2009 with recommendation for non-certification. 10 pages of medical records were reviewed. The provider was on vacation and unavailable for a peer discussion. Rationale for denial states, the patient does not meet the criteria in ODG for a meniscectomy as there is no evidence on imaging studies of a meniscal tear. Additionally, it is stated that the patient has failed conservative care; however the physical therapy note submitted shows that the patient did go for a physical therapy evaluation; however, did not show up for any follow-up appointments and was subsequently discharged from therapy.

Request for reconsideration left knee arthroscopy partial meniscectomy plus/minus lateral release was considered in review on January 26, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. 31 pages of medical records were reviewed. The claimant on physical examination has good ROM and no effusion. She is stated to have positive McMurray's and positive medial patellar facet and lateral facet tenderness. MRI of June 2009 showed small joint effusion, Baker's cyst with no evidence of internal derangement. X-rays show mild degenerative joint disease of the knee. She has had unloader brace, steroid injections (?) and physical therapy. Rationale for denial states, the claimant has no sensation of giving way, locking, clicking or popping. MRI shows no internal derangement of the knee.

Request was made for an IRO.

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

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.

The patient has not been documented to have completed PT as the therapist discharge report of July 30, 2009 notes she was assessed on June 24, 2009 but was not seen for follow-up appointments and was discharged on July 30, 2009. Orthopedic assessment of August 20, 2009 was significant for medial joint line tenderness, a positive McMurray and some tenderness over the medial patellar facet and lateral patellar facet. Otherwise, there was no effusion, no laxity of the ligaments, no giving way, no popping or clicking or locking. There is no report of medication use or injections. She did wear an unloader brace for a time. The provider notes the reading radiologist interpretation of the MRI as showing no internal derangement and provides his personal

interpretation of, a small undersurface medial meniscus tear and probable patellofemoral compression issues.

On November 25, 2009 it was reported that she saw an independent doctor several weeks prior for opinions regarding the recommended but denied knee surgery. An IME report has not been submitted. The IME reportedly agrees with the diagnosis of medial meniscus tear and patellofemoral issues per their report and believes that surgery was indicated. Again, there is no effusion at the left knee and there is good range of motion. There is no mediolateral instability. Lachman and pivot test are negative. There is medial joint line tenderness and a positive McMurray's. The lateral retinaculum is very tight. Impression is torn medial meniscus and patellofemoral issues.

First line review denial rationale noted there is no evidence on imaging studies of a meniscal tear. Additionally, it is stated that the patient has failed conservative care; however the physical therapy note submitted shows that the patient did go for a physical therapy evaluation; however, did not show up for any follow-up appointments and was subsequently discharged from therapy.

Second line review denial rationale noted she has had unloader brace, steroid injections (?) and physical therapy. Rational for denial states, the claimant has no sensation of giving way, locking, clicking or popping. MRI shows no internal derangement of the knee.

Conservative care criteria do not appear to have been met. PT and medication are not fully clarified; the patient appears to have not shown up for any of the PT ordered. The patient has only one of the required two objective findings; she has joint pain, but no swelling, no clicking popping or giving way. She does have sufficient objective criteria of joint pain and a positive McMurray. A meniscal tear is not identified on MRI per the reading radiologist; however, the provider, his colleague and reportedly the IME doctor believe there is meniscal and patellofemoral pathology. While technically not all the criteria have been documented, the patient does appear to have persisting meniscal and patellofemoral issues despite bracing, rest, and over one year duration of symptoms and activity limitation. It would be reasonable to proceed with more definite examination via arthroscopy with repairs as needed.

Therefore, my recommendation is to disagree with the previous non-certification for left knee arthroscopy partial meniscectomy plus/minus lateral release.

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 06-30-2010 Knee and Leg Chapter - 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).

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.

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.

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.

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.