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**DATE OF REVIEW:** 12/27/2009

**IRO CASE #:**

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

IRO - Arthroscopy with Partial Lateral Meniscectomy of the Left knee between 11/24/09 and 1/23/2010 AND Assistant Surgeon

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Trauma, Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

**REVIEW OUTCOME:**

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
IRO - Arthroscopy with Partial Lateral Meniscectomy of the Left knee between 11/24/09 and 1/23/2010 <u>AND</u> Assistant Surgeon	29881	-	Upheld

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

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		18		
2	IRO Carrier/URA Records		60		
3	IRO Requestor Records		22		

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who fell suffering an undisplaced lateral tibial plateau fracture on xx/xx/xx. She was treated for the lateral tibial plateau fracture utilizing knee immobilizer and crutch supported ambulation. She has suffered persistent pain. Apparently, she also suffered bilateral wrist fractures on 09/22/09 and the left wrist fracture required a surgical procedure and the right wrist fracture was casted. An MRI scan of the left knee (08/28/09) has revealed a posterior horn tear medial meniscus. A painful positive McMurray's test is reported. A request has been submitted for pre authorization for arthroscopy left knee with partial lateral meniscectomy and surgical assistant. The request was considered and denied; reconsidered and denied.

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

There may have been a mistake in transition from the results of the MRI scan to the medical records of clinical evaluations. Clearly, the MRI report indicates a posterior horn medial meniscus tear and the request is for preauthorization of arthroscopic lateral meniscus tear. There is no documentation of physical therapy treatment. There is no documentation of locking or giving way.

1. Is the arthroscopic surgery with partial lateral meniscectomy left knee medically necessary and appropriate?

No. At this time there is no indication that an arthroscopic surgical procedure and partial lateral meniscectomy should be performed. The confusion between the MRI findings and the surgical request should be clarified. It would be clearly inappropriate to perform partial lateral meniscectomy when the lateral meniscus is normal and the medial meniscus is torn. There is no indication of mechanical symptoms. The prior denials of this preauthorization request were appropriate and should be upheld.

Meniscectomy	<p>Recommended as indicated below for symptomatic meniscal tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings. (<a href="#">Kirkley, 2008</a>) 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. (<a href="#">Englund, 2001</a>) 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. (<a href="#">Howell-Cochrane, 2002</a>) 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. (<a href="#">Solomon, 2004</a>) 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</p>
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	<p>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 <a href="#">Meniscal allograft transplantation</a>. (<a href="#">Harner, 2004</a>) (<a href="#">Graf, 2004</a>) (<a href="#">Wong, 2004</a>) (<a href="#">Solomon-JAMA, 2001</a>) (<a href="#">Chatain, 2003</a>) (<a href="#">Chatain-Robinson, 2001</a>) (<a href="#">Englund, 2004</a>) (<a href="#">Englund, 2003</a>) (<a href="#">Menetrey, 2002</a>) (<a href="#">Pearse, 2003</a>) (<a href="#">Roos, 2000</a>) (<a href="#">Roos, 2001</a>) 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. (<a href="#">Siparsky, 2007</a>) 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 <i>New England Journal of Medicine</i>. 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. (<a href="#">Kirkley, 2008</a>) 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. (<a href="#">Englund, 2008</a>) Arthroscopic meniscal repair results in good clinical and anatomic outcomes. (<a href="#">Pujol, 2008</a>) 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. (<a href="#">Englund, 2009</a>)</p> <p><b>ODG Indications for Surgery™ -- Meniscectomy:</b>  <b>Criteria</b> 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):</p> <ol style="list-style-type: none"> <li>1. <b>Conservative Care:</b> (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. PLUS</li> <li>2. <b>Subjective Clinical Findings (at least two):</b> Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS</li> <li>3. <b>Objective Clinical Findings (at least two):</b> Positive McMurray's sign. OR Joint line tenderness. OR Effusion. OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS</li> <li>4. <b>Imaging Clinical Findings:</b> (Not required for locked/blocked knee.) Meniscal tear on MRI.</li> </ol> <p>(<a href="#">Washington, 2003</a>)</p>
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**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 KNOWLEDGBASE
- 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
- X 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)