



Notice of Independent Review Decision-WC

CLAIMS EVAL

CLAIMS EVAL REVIEWER REPORT - WC

*Utilization Review and
Peer Review Services*

DATE OF REVIEW: 4-13-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient arthroscopic medial meniscectomy and lateral release of the left knee

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

- MD., office visits on 1-20-10, 1-21-10, 1-28-10, 2-11-10, and 2-23-10.
- 1-20-10 X-rays of the left knee.
- 1-29-10 MRI of the left knee.
- MD., office visits on 2-3-10, 2-9-10, and 3-26-10.
- 2-5-10 Utilization Review performed by, MD.
- 2-16-10 Utilization Review was performed by, MD.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 1-20-10, the claimant was seen by, MD., noted the claimant complained of left knee pain. On exam, the claimant has evidence of effusion. There is a question as to whether the claimant had a left knee dislocation. He was provided with a prescription for Lortab and Naprosyn. The claimant was continued at work with restrictions.

X-rays of the left knee dated 1-20-10 was unremarkable.

On 1-21-10, the claimant was again seen by Dr. for x-rays review. On exam, the claimant is tender at the medial side with evidence of effusion. The claimant was continued with his medications. The evaluator recommended an MRI of the left knee. The claimant was continued with the use of a knee brace.

Follow up with Dr. on 1-28-10 notes the claimant is wearing his brace at work. The claimant reported that he feels as if his knee is out of place. The claimant is returned to work with restrictions.

1-29-10 MRI of the left knee shows tear posterior horn medial meniscus, medial patellar retinaculum tear with associated edema and joint effusion. There is chondromalacia articular surface medial femoral condyle.

On 2-3-10, , MD., evaluated the claimant. He noted the claimant was complaining of left knee pain. This is a 49 year old white male gentleman who had a twisting injury of his left knee on January 20, 2010 while he was at work. He had some medial knee pain with some swelling at that time which became quite painful over the next several hours. He has continued with some medial left knee pain and the swelling has improved. He complains of popping, catching and a feeling of giving way. He has no prior history of trouble with the left knee. Examination of the left knee shows a one plus effusion. The knee is stable. There is medial joint line tenderness and tenderness of the medial patellar retinaculum. Sensory and motor exam are intact. MRI of the left knee shows a medial meniscus tear and a torn medial patellar retinaculum. Impression: Left knee medial meniscus tear and medial patellar retinacular tear. The evaluator reported the claimant continues to be quite symptomatic with this. He is unable to stand for long periods of time and is unable to do any climbing. He would like to proceed with knee arthroscopy. The claimant was continued at work with restrictions.

On 2-5-10, a Utilization Review performed by, MD., noted It is the opinion of the reviewing physician that the submitted documentation indicates the claimant is 15 days post injury and has not had any conservative treatment. The documentation does not reflect locking of the knee. The documentation does not mention any of the patellar abnormalities required by ODG for the performance of lateral release. The proposed surgery does not appear to be consistent with ODG at this time. 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.

Follow up with Dr. dated 2-9-10 notes the claimant complains of worsening of pain of his left knee since the injury. He continues with medial side pain with popping and swelling. The evaluator recommended proceeding with surgical intervention.

On 2-16-10, a Utilization Review was performed by MD. It is the opinion of the reviewing physician that this male was injured x/xx/xx when he twisted his knee at work. The claimant on 1-23-10 was noted to have some medial knee pain and swelling at the time of the injury which had become painful over the next several hours. The MRI revealed a medial meniscal tear with a medial patellar retinacular tear. The claimant indicated he was unstable to stand for long periods of time and was unable to do any climbing. In follow up of 2-9-10, Dr. indicated his request was for an arthroscopic partial meniscectomy and possible debridement of the medial retinaculum. Previously a non-authorization was recommended as the claimant had not had conservative treatment provided and the documentation did not reflect locking of the knee or indications for a lateral retinacular release. At this time, there still is not an indication of physical therapy (PT) having been performed or medication pre scribed. Therefore, the evaluator agreed with the prior reviewer. The clinical information does not support an emergent type of arthroscopic procedure before an appropriate course of conservative treatment as indicated in ODG criteria.

Follow up with Dr. dated 3-26-10 notes the claimant is 2 months post injury. He continues to have medial knee pain. He had nine sessions of physical therapy and has had no improvement of his pain or his function. He continues to have some popping and catching but no locking, He has been taking Naprosyn 500 milligrams b.i.d. without any improvement. Examination of the left knee shows medial joint line tenderness and tenderness at the medial retinaculum. There is pain with a McMurray's test. There is also some anterior lateral tenderness adjacent to the patella. There is a trace effusion. The knee is stable. Sensory and motor exam are intact. Impression: Left medial meniscus tear with medial retinacular tear. The evaluator reported the claimant has tried conservative management with physical therapy and anti-inflammatory medications without any improvement. The evaluator reported it would be prudent to proceed with left knee arthroscopy, partial meniscectomy and debridement. He will again submit this to the insurance company again for consideration. He may return to work with some restrictions.

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

Claimant sustained a twisting injury to the left knee. Diagnostic studies have demonstrated medial meniscal tear along with tear of the medial retinaculum. From the medical records, claimant has had minimal rehabilitation treatment. The last office note relates only 9 physical therapy visits.

Medical records do not reflect the claimant is performing a home exercise program working on strengthening and range of motion of the knee. The claimant may require surgery in the future, but he has not been afforded the usual nonsurgical care for a knee injury. Therefore, the request for an outpatient arthroscopic medial meniscectomy and lateral release of the left knee is not reasonable or necessary at this time.

ODG-TWC, last update 3-26-10 Occupational Disorders of the Knee – 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)

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.

Per ODG 2010 regarding retinacular release -- Lateral retinacular release:

Criteria for lateral retinacular release or patella tendon realignment or maquet procedure:

1. Conservative Care: Physical therapy (not required for acute patellar dislocation with associated intra-articular fracture). OR Medications. PLUS

2. Subjective Clinical Findings: Knee pain with sitting. OR Pain with patellar/femoral movement. OR Recurrent dislocations. PLUS

3. Objective Clinical Findings: Lateral tracking of the patella. OR Recurrent effusion. OR Patellar apprehension. OR Synovitis with or without crepitus. OR Increased Q angle >15 degrees. PLUS

4. Imaging Clinical Findings: Abnormal patellar tilt on: x-ray, computed tomography (CT), or MRI.

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
- 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)