

Notice of Independent Review Decision

**DATE OF REVIEW:** 11/12/10

**IRO CASE #:**

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

Medical necessity for surgery to left knee (left knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy)

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

The physician performing this review is Board Certified, American Board of Orthopaedic Surgery. He has been a medical director in a Sports Physical Therapy facility, has served in various positions as course instructor related to orthopedics as well as a presenter of lectures of which he authored and has been involved in research projects published in related journals. He has been in practice since 2004.

**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.

Surgery of the left knee is not indicated and appropriate.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

# The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-443

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Records received: 17 page fax 11/1/10 Texas Department of Insurance IRO request, 36 page fax 11/1/10 Provider information including administrative and medical records and 110 page fax 11/4/10 URA Response to disputed services with administrative and medical records.

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

This is a now female claimant with a reported left knee injury that occurred while at work on xx/xx/xx/x when she twisted her left knee. She sustained a contusion of the left knee and was found to have a medial meniscus tear. She underwent a left knee arthroscopy, partial medial meniscectomy and chondroplasty of the medial femoral condyle the patella and patellofemoral joint on 05/21/08.

Her current diagnosis includes tears of the medial and lateral meniscus of the left knee. Provided documentation revealed the claimant did well following her 05/21/08 surgery and completed physical therapy with a release back to full duty on 06/30/08. On 07/18/08, Dr. declared the claimant had a 1 percent whole person impairment rating for her partial medial meniscectomy and compensable injury. On 06/29/10, she presented for evaluation with a two-month history of increasing pain with weight bearing activities along with mechanical symptoms that included popping, buckling, snapping and giving way. Left knee x-rays demonstrated a bone spur of the medial tibial plateau with a well-circumscribed lesion on the distal aspect of the medial femoral condyle consistent with either avascular necrosis (AVN) or osteochondritis desiccans. A left knee MRI obtained on 08/11/10 demonstrated postop changes of the medial meniscus with a possible recurrent medial meniscus tear and a subtle nondisplaced horizontal cleavage tear of the lateral meniscus body. There was high-grade chondromalacia of the medial femoral condyle along with findings of anterior cruciate ligament degeneration/cyst and a nonacute osteochondral compression fracture of the medial femoral condyle versus degeneration. The 08/16/10 exam demonstrated a positive McMurray with pain and popping along with pain with weightbearing. Conservative treatment included medication management, bracing and activity modifications without relief. Dr. noted that physical therapy was not indicated in this diagnosis and requested authorization to proceed with a left knee arthroscopy, partial medial meniscectomy and partial lateral meniscectomy.

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

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This is a female who has had previous knee arthroscopy. Postoperatively she did well and returned back to work with a 1 percent impairment rating, but then she had subjective mechanical symptoms. There is no documentation of motion and no evidence of a locked knee or effusion. However, postoperatively she has had recent radiographs that demonstrate spurring of the medial tibial plateau and medial femoral condylar lesion. A followup MRI demonstrates postoperative changes of the medial and lateral menisci which were previously operated on which could represent either new tears or postsurgical changes as well as chondromalacia of the medial femoral condyle as well as an osteochondral compression fracture of the medial femoral condyle.

Conservative treatment has been documented as medical management, brace and activity modification however it has not been exhaustive. There is an osteochondral lesion of the medial femoral condyle and degeneration which typically injections with viscosupplementation therapy and consideration of bracing should be considered first and foremost in light of the fact the previous surgery and its clinical scenario.

## **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

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- 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---- SEE BELOW**
- 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)**

## REFERENCES:

California MTUS – ACOEM OMPG, Second Edition, (2004), Chapter 13, pages 344-345

Meniscus Tears

Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear—symptoms other than simply pain (locking, popping, giving way, recurrent effusion); clear signs of a bucket-handle tear on examination (tenderness over the suspected tear but not

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over the entire joint line, and perhaps lack of full passive flexion); and consistent findings on MRI. However, patients suspected of having meniscal tears, but without progressive or severe activity limitation, can be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize healing. 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 may not be equally beneficial for those patients who are exhibiting signs of degenerative changes.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010  
Updates: Knee/Leg – Meniscectomy

### **Meniscectomy:**

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

### **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.