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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 04/07/2011

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 Surgeon, 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

Right knee arthroscopy, drill of osteochondral defect, excision of arthritic spurs and possible meniscectomy between 1/28/2011 and 3/29/2011

REVIEW OUTCOME

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

Upheld (Agree)

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 07-08-10 through 02-01-11 provider visit notes from Dr. - 10 visits.
- o 07-08-10 Radiology report, unsigned - from Hospital
- o 09-02-10 Initial evaluation report from Dr. with invoice
- o 09-30-10 Letter to employee re DD examination from TDI
- o 10-06-10 Medical report from Dr.
- o 10-18-10 Fax cover note requesting Euflexxa injections from Dr.
- o 10-18-10 Fax note from request for knee sx
- o 10-29-10 Designated Doctor report from MD
- o 01-04-11 Initial report, unsigned
- o 01-25-11 Medical report from Dr.
- o 02-02-11 Adverse Determination letter
- o 02-02-11 Peer Review with non-certification for knee surgery
- o 03-02-11 Attorney letter of appeal
- o 03-08-11 Adverse Determination letter
- o 03-08-11 Adverse Determination review on appeal
- o 03-16-11 Request for IRO from the Claimant
- o 03-18-11 Notice of Utilization Review
- o 03-18-11 Notice to Network of Case Assignment from TDI
- o 03-21-11 Confirmation of Receipt of Request for IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female employee who sustained an industrial injury to the right knee on xx/xx/xx when she fell on some screws that were lying on the ground. Co-morbid conditions include hypertension, overweight and tobacco abuse. She also has issues with knee extension due removal of a fracture patella in 1984.

MRI report dated July 8, 2010 reportedly noted impression: 1. Absent patella, possibly representing prior patellar removal. 2.

Some minimal increased signal of the medial aspect of the quadriceps tendon region extending to the vastus medialis myotendinous region which could be consistent with either that of some postoperative change versus incomplete tear or strain and some slight separation of the vastus medialis quadriceps tendon component from the main quadriceps tendon. 3. A 1.7 cm diameter intraosseous cyst, probably an intraosseous ganglion involving the anterior lateral femur or lateral trochlear groove. Minimal degenerative changes with some cartilage loss and some hypertrophic osteophytosis with a focal area of osteochondral defect involving the medial femoral condyle. Correlation with clinical and physical findings suggested. A referral was planned.

The patient was examined by her provider on July 8, 2010. She fell the prior week and complains of bilateral hip pain and right knee pain. She reports right knee pain of 3/10. She had an MRI. She is 5' 1" and 190 pounds (BMI 35.9). She also notes heartburn.

Provider treatment notes dated August 11, 2010 indicates the patient is wearing a right knee brace and has some limp. No pertinent clinical data is noted in regard to the knee.

Provider treatment notes of August 30, 2010 are illegible. Apparently right knee meniscectomy is planned for posttraumatic arthritis.

The patient was evaluated orthopedically on September 2, 2010. MRI of July 8 showed intact collateral and cruciate ligaments and intact menisci. There is tricompartmental arthritis and hypertrophic osteophytosis. There is no joint effusion. There was an incidental 1.7 cm in diameter intraosseous ganglion cyst. There was an osteochondral defect involving the medial femoral condyle. She complains of cramping pain within the knee. She has been off work for two days. She has not had any swelling since the injury. There is no effusion on examination. There is full ROM. There is no joint line tenderness and McMurray's test is normal. The collateral and cruciate ligaments are intact. X-rays confirm mild to moderate tricompartmental arthritis. Impression is contusion of the right knee. Corticosteroid injection was provided this visit. She was encouraged to do pool exercises. She would return to work after several days of rest. She was instructed in home exercises and icing.

On September 7, 2010 the provider noted right knee pain of 9/10, swelling and inability to bend the knee. She has knee effusion and a meniscal tear. An injection is planned. On September 21, 2010 the patient has pain of 8/10. She is also anxious and depressed. She will see the orthopedic specialist on October 8, 2010.

Orthopedic reevaluation of October 6, 2010 noted four days relief with the corticosteroid injection. She walks with a cane. She has not returned to work. She has full ROM and there is no effusion. The knee is still quite painful along the joint lines and she has tricompartmental arthritis. Recommendation is for joint fluid injections (Euflexxa). She may need a total knee joint replacement, although she does not have a patella and is relatively young.

Provider notes of October 6, 2010 indicate the patient has seen the specialist and he removed fluid from both knees. She will start a series of 3 Hyalgan injections to the right knee.

October 18, 2010 fax note requests arthroscopy to include drilling of osteochondral defect and excision of arthritic spurs and possible meniscectomy.

On October 25, 2010 the provider noted 3 three knee injections had been provided. She has some effusion. She will start Darvocet and Lodine. Some of the notes are illegible.

Designated Doctor report dated October 29, 2010 notes the patient slipped and fell on her flexed knee while at work. Her patella was removed many years prior after an auto accident. Her private physician did x-rays and an MRI. X-rays showed mild to moderate tri-compartmental arthritis. The MRI showed intact collateral, cruciate ligaments and menisci. There was tricompartmental arthritis and hypertrophic osteophytosis. There was no joint effusion. There was an incidental ganglion cyst of 1.7 cm in diameter and an osteochondral defect involving the medial femoral condyle. She was seen by an orthopedic specialist who provided an injection and took her off work. She was encouraged to do water therapy and HEP. She was last seen on October 1, 2010 and the current recommendation is for a course of Euflexxa injections once every 3 weeks through January 11, 2011. She is using Darvocet, Etodolac and Hydrocodone. She has popping in the knee and decreased ROM. She rates her pain as 7/10. She is slightly overweight. She uses a cane. She has normal gait. There is no tenderness at the knee. Grind test is positive. Bounce Home test is positive. The knee is stable with testing. McMurray's is negative. ROM is decreased slightly with full effort. She is not yet MMI but should be by 2/13/11. She should get the Euflexxa injections and return for MMI consideration about 2/13/11.

On November 23, 2010 the provider noted medications of Darvocet, Etodolac, Ziac and Pristiq. She complains of pain at the side of the right knee. She reports some instability and giving way. A hinged knee brace is planned. Some of the notes are illegible. On December 31, 2010 she still feels unstable and is using a hinged knee brace. She is getting depressed. She cannot bend the knee. She has a persisting cough and earache. Her weight is 201 pounds. Some of the notes are illegible.

The patient was seen on January 4, 2011 for follow-up of Euflexxa injections. She relates pain of 1/10. There is frequent

swelling(?). Her history includes hypertension. She does smoke. Assessment is localized osteoarthritis and knee contusion. Her patella was removed in 1984 so she has issues with extending her knee. She just finished a series of Euflexxa injections. A knee brace was suggested, but she stated she already has one. She is requesting a total knee replacement. Other opinions will be sought from the examiner's colleagues and she will return in three weeks.

The patient was seen in follow-up on January 25, 2011. Last visit right knee TKR was discussed. Right knee x-rays taken this visit show spurs on the tibia and osteoarthritis. She has spurs which could be removed and give her some comfort. Knee joint replacement may not be a good idea for her. The spurs are on the tibia. Recommend knee scope as soon as possible to remove the spurs and osteophytes.

Handwritten provider notes dated February 1, 2011 indicates medications are refilled (Lorcet Plus, Etodolac, Ziac, Pristiq and Protonix). She reports some shooting pains in the left hip. She is prescribed Vicodin ES and Flexeril(?).

Request for right knee arthroscopy, drill of osteochondral defect, excision of arthritic spurs and possible meniscectomy between 1/28/2011 and 3/29/2011 was considered in review on February 2, 2011 with recommendation for non-certification. Per the reviewer, she fell on some screws lying on the ground. MRI of July 8, 2010 revealed an absent patella and some minimal increased signal of the medial aspect of the quadriceps tendon region extending to the vastus medialis myotendinous region, which could be consistent with either that of some post-operative change versus incomplete tear or strain and some slight separation of the vastus medialis quadriceps tendon component from the main quadriceps tendon. A 1.7 cm diameter ontraosseous cyst, probably an intraosseous ganglion involving the medial meniscus was noted. Arthritic and degenerative changes with some cartilage loss and some hypertrophic osteophytosis with a focal area of osteochondral defect involving the medial femoral condyle was noted. On January 4, 2011 she reported right knee pain of 1/10. Jensen scale value of the right knee is at 11/100 possible points and 49/100 possible points to the left knee. Current medical report dated 1/25/11 indicates right knee pain of 3/10. She also complained of swelling of the right knee with painful arthritis. X-ray showed spurs on the tibia and osteoarthritis. DD opinions of 10/29/10 indicated she is not at MMI. Response to Euflexxa is not reported. A peer discussion was attempted but not realized. ODG does not specifically address the request for excision of arthritic spurs. On review of the January 25, 2011 report, the patient does not exhibit positive McMurray's sign, joint line tenderness, limited ROM, locking, clicking or popping or crepitus. There is no clear documentation of conservative treatment. There is no documentation that PT was rendered. Pharmacotherapy including drug name, dosage, frequency and response are not mentioned in the report.

Per letter dated March 2, 2011 from the patient's attorney the requested treatment is reasonable and necessary and delay of treatment will make the patient's condition worse.

Request for reconsideration right knee arthroscopy, drill of osteochondral defect, excision of arthritic spurs and possible meniscectomy between 1/28/2011 and 3/29/2011 was considered in review on March 8, 2011 with recommendation for non-certification. A peer discussion was conducted with the requesting provider. The provider noted that more recent x-rays taken in his office are not consistent with the prior imaging reports both x-rays and MRI as interpreted by himself of tricompartmental osteoarthritis. His recent x-rays showed more mild medial compartment degenerative joint disease. The patellofemoral and lateral compartments were not affected. He was aware of this discrepancy and identified that he will provide an explanation for such a disparity as well as official radiology readings that concur with his findings in the context of a reconsideration/appeal request. The records indicate a prior adverse determination mainly based lack of conservative care. However, additional information shows swelling and painful arthritis and the MRI findings show arthritic and degenerative changes with some cartilage loss and some hypertrophic osteophytosis with a focal area of osteochondral defect involving the medial femoral condyle. Treatment has included injections. However, given extensive findings of degenerative disease on imaging, the proposed procedure would not likely help the patient. The provider has stated additional explanation will be forthcoming to explain the disparity between prior imaging reports and his interpretation of those reports and more recent imaging studies.

Request was made for an IRO.

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

ODG: 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):

Conservative care: (Not required for locked/blocked knee.) Physical therapy or medication or activity modification plus subjective findings of joint pain or swelling or a feeling of give way or locking, clicking, or popping. Plus, positive McMurray's sign or joint line tenderness or effusion, limited range of motion, locking, clicking, popping or crepitus. Plus imaging findings: (Not required for locked/blocked knee.) of meniscal tear on MRI.

ODG: Chondroplasty: Recommended as indicated below. Not recommended as a primary treatment for osteoarthritis, since

arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical therapy and medical treatment.

MRI showed minimal degenerative changes with some cartilage loss and some hypertrophic osteophytosis with a focal area of osteochondral defect involving the medial femoral condyle. On September 2, 2010 the orthopedic provider interpreted the imaging to show, tricompartmental arthritis and hypertrophic osteophytosis. TKR was discussed, however, the patient has a BMI of more than 30 and is close to 50 years of age. She would not be a candidate for TKR. The provider also currently does not believe the patient is a candidate for TKR. Tricompartmental osteoarthritis is now in doubt per the provider based on more recent imaging. Additional explanations for discrepancies in more recent imaging with prior imaging have been promised by the provider and remain pending at this time.

On October 29, 2010 the Designated Doctor noted, popping in the knee and decreased ROM. She rates her pain as 7/10. She is slightly overweight. She uses a cane. She has normal gait. There is no tenderness at the knee. Grind test is positive. Bounce Home test is positive. The knee is stable with testing. McMurray's is negative. ROM is decreased slightly with full effort. She is not yet MMI but should be by 2/13/11. She should get the Euflexxa injections and return for MMI consideration about 2/13/11. It is noted that the patient has had knee extension issues since removal of a fractured patella in 1984. Her body habitus (BMI 35.9) would also restrict knee ROM.

First level denial rationale notes, the January 25, 2011 report indicates the patient does not exhibit positive McMurray's sign, joint line tenderness, limited ROM, locking, clicking or popping or crepitus. There is no clear documentation of conservative treatment. There is no documentation that PT was rendered. Pharmacotherapy including drug name, dosage, frequency and response are not mentioned in the report.

Second level rationale for denial notes, the provider has stated additional explanation will be forthcoming to explain the disparity between prior imaging reports and his interpretation of those reports and more recent imaging studies. In addition, given extensive findings of degenerative disease on imaging, the proposed procedure would not likely help the patient.

The reports contain a number of contradictions. Per the DD the patient has normal gait yet she is using a cane. She is slightly overweight but has a BMI of over 35. On September 2, 2010 there is no joint line tenderness and McMurray's test is normal. The collateral and cruciate ligaments are intact. Reports consistently indicate no instability, yet she has been using a knee brace and on November 23, 2010 reports giving way and is provided a hinged knee brace. She was noted to have tricompartmental osteoarthritis but more recent imaging does not support this (explanation still pending). The patient has historically had issues with knee extension due a removed patella. There is a chondral defect. According to the provider, imaging is not inconclusive. However, his explanations remain pending.

There are too many issues that need further clarification to support proceeding with the recommended surgery at this time.

Therefore, my recommendation is to agree with the previous non-certification for right knee arthroscopy, drill of osteochondral defect, excision of arthritic spurs and possible meniscectomy between 1/28/2011 and 3/29/2011.

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 - 03-21-2011 Knee and leg Chapter:

Diagnostic Arthroscopy:

Recommended as indicated below. Second look arthroscopy is only recommended in case of complications from OATS or ACI procedures, to assess how the repair is healing, or in individual cases that are ethically defensible for scientific reasons, only after a thorough and full informed consent procedure. (Vanlauwe, 2007) In patients with osteoarthritis, the value of MRI for a precise grading of the cartilage is limited, compared to diagnostic arthroplasty. When the assessment of the cartilage is crucial for a definitive decision regarding therapeutic options in patients with osteoarthritis, arthroscopy should not be generally replaced by MRI. The diagnostic values of MRI grading, using arthroscopy as reference standard, were calculated for each grade of cartilage damage. For grade 1, 2 and 3 lesions, sensitivities were relatively poor, whereas relatively better values were noted for grade 4 disorders. (von Engelhardt, 2010)

ODG Indications for Surgery -- Diagnostic arthroscopy:

Criteria for diagnostic arthroscopy:

1. Conservative Care: Medications. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS
3. Imaging Clinical Findings: Imaging is inconclusive.

(Washington, 2003) (Lee, 2004)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

Meniscectomy:

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.

(Washington, 2003)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

Chondroplasty:

Recommended as indicated below. Not recommended as a primary treatment for osteoarthritis, since arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical therapy and medical treatment. (Kirkley, 2008) See also Meniscectomy.

ODG Indications for Surgery -- Chondroplasty:

Criteria for chondroplasty (shaving or debridement of an articular surface), requiring ALL of the following:

1. Conservative Care: Medication. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Joint pain. AND Swelling. PLUS
3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS
4. Imaging Clinical Findings: Chondral defect on MRI