

# CASEREVIEW

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Notice of Independent Review Decision

**DATE OF REVIEW:** August 31, 2011

**IRO CASE #:**

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

Left Knee Arthroscopy with Meniscectomy and Chondroplasty between 8/1/2011 and 9/30/2011.

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

**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**

February 22, 2010: Operative report by MD. Postoperative diagnosis: Patellar chondromalacia, acute tear of the medial meniscus, pain in the knee joint, healing MM tear. Procedures: Left knee diagnostic arthroscopy. Left knee arthroscopic chondroplasty of the patella.

August 20, 2010: Peer Review by MD where the following opinions were given: 1. The compensable injury for the event of November 30, 2009 is a left knee medial meniscal tear. 2. The claimant does have pre-existing conditions of ordinary disease of life that may impact the treatment and rehabilitation of the compensable injury of xx/xx/xxxx. The claimant has left knee patellar chondromalacia and small Baker's cyst documented by MRI scan of December 23, 2009, and pre-existing degenerative changes of the talonavicular joint, osteochondral lesion of the medial talar dome, ossific fragments in the medial malleolus suggestive of prior trauma, distal posterior tibial tendinosis, and subcutaneous edema at the posteromedial aspect of the ankle with hindfoot valgus. The distal posterior tibial tendon was noted to have chronic tendinosis. These conditions are degenerative in nature, pre-existing, and not causal or related to the compensable event of xx/xx/xxxx. 3. The effects of the original compensable injury, left knee medial meniscal tear, have resolved. Current and future medical treatment is not reasonably required for the compensable event of xx/xx/xxxx, left knee medial meniscal tear, which was resolved surgically. For the compensable event, left knee medial meniscal tear, the claimant requires no further referrals to specialists, invasive testing, durable medical equipment, formal physical therapy, chiropractic care, physician office visits, surgery, work hardening or work condition, chronic pain management programs, individual psychological counseling, prescriptive medications, or injections. The injured employee can continue over-the-counter anti-inflammatory medication and/or analgesic medication as needed for symptoms. 13. Pain management care is not clinically indicated for the compensable event of xx/xx/xxxx, which includes left knee medial meniscal tear only.

November 4, 2010: The claimant was evaluated by MD. Chief complaint: knee pain. Dr. noted a sympathetic block of the lower extremity had been ordered considering causalgia as the claimant's contributing source of pain. PE: Shows sensitivity over the knee which is a bit improved. Good extension of the knee and flexion. Stable knee. Diagnosis: Chondromalacia of patella, tear of medial cartilage or meniscus of knee current. Recommendation: Second opinion with Dr. Also arthroscoping the knee under a sympathetic block done by Dr.

November 22, 2010: The claimant was evaluated by MD. PE: Walking with a limp and using crutches and a walking boot. Left knee demonstrates healed arthroscopic portal sites. No swelling, no hypersensitivity, no erythema, no warmth, no rashes, no effusion. There was mild tenderness along the medial femoral condyle and medial joint line. No varus or valgus instability. Lachman was negative. Range of motion was 0 degrees to 120 degrees. X-rays of the left knee demonstrated osteopenia. A bone scan indicated increased activity in the patellofemoral compartment and lateral compartment. Dr. diagnosis: Internal derangement, left knee with ongoing pain. Recommendations: A new MRI. If the MRI comes back normal, then he would be a good candidate for a sympathetic block.

November 23, 2010: MRI of the left knee read by MD. Impression: 1. Medial meniscus and lateral meniscus intrasubstance high signal without meniscal tear. 2. Medial tibial plateau mild cortical irregularity.

December 1, 2010: The claimant had a follow-up evaluation by MD. PE: No hypersensitivity. No significant change in sweat pattern or temperature. He was hesitant to bear weight and has some mild diffused tenderness. Recommendations: Evaluation by a pain specialist to consider a regional block for a possible sympathetic dystrophy or regional pain syndrome.

January 3, 2011: The claimant had a follow-up evaluation by MD. Recommendations: Sympathetic block.

February 7, 2011: Peer Review by MD where the following opinions were given: 1. Yes, based on the objective medical evidence reviewed, the mechanism of injury, and the multiple physical exams, the injured employee's left knee strain status post left knee arthroscopy has resolved and reached an endpoint to treatment. 2. No, based on the objective medical evidence reviewed, the mechanism of injury, and the multiple physical exams, the reported depression and anxiety are pre-existing ordinary diseases of life and not causally related to the resolved compensable injury of left knee sprain status post left knee meniscectomy.

February 10, 2011: The claimant had a follow-up evaluation by MD. PE: Showed some coolness to the knee. There was sensitivity over the patella. Flexion near full. There was still tenderness along the medial joint line. Recommendations: The claimant demonstrates many findings of complex regional pain syndrome including osteopenia in the patella on x-ray, hypersensitivity over the skin, diminished blood flow in the skin about the extremity. For these reasons, Dr. felt that it cannot be ignored and not addressed. Dr. recommendations would be sympathetic block.

March 10, 2011: The claimant had a follow-up evaluation by MD. Recommendations: Second opinion with Dr.

April 5, 2011: The claimant was evaluated by MD. PE: No significant color difference in the lower extremities. The left lower extremity does appear by touch to be cooler than the right lower extremity, this started below the knee joint into the lower aspect of the leg. The claimant had deconditioning with some muscle loss of the quadriceps and hamstrings, as well as in the calf on the left side as compared to the right side. Examination of the knee showed that he had 1 to 2+ drawer and Lachman's test. When the claimant relaxed, there was a pivot shift present, not grossly unstable. There was discomfort in the medial joint line to palpation. There was positive McMurray's test with a clicking in the knee joint, which occurred not only with the pivot shift, but with McMurray's maneuver and this reproduced some of the symptomatology the claimant had been having. Pain at the patellofemoral joint and positive patella inhibition test. X-rays showed disuse osteopenia around the knee joint and the patella in the left, as compared

to the right on four views, the joint spaces of the patellofemoral joint and the femoral tibial joint were satisfactorily maintained. Diagnosis: Tears of the menisci although they are read as mucoid degeneration. A problem with the anterior cruciate ligament possibly a tear still covered by the synovium possibly adherent to the posterior cruciate because of the instability that he has at the present time. Recommendations: Dr. agreed with Dr. that the claimant should initially have a sympathetic block to see if there is any decrease in the symptomatology with that test. If it does not give any significant relief than a he would need a repeat arthroscopic examination of the left knee to evaluate the patellofemoral joint.

April 13, 2011: The claimant was evaluated by MD who noted that after being evaluated by an independent medical adviser with an IME designated doctor by the insurance company, which at the present time is allowing for the diagnostic study of a left sympathetic nerve block and therapeutic procedure. PE: The left knee showed allodynia, hyperesthesia, pseudomotor changes, and discoloration. Impression: Left lower extremity complex regional pain syndrome type I. Chronic intractable pain syndrome. Chronic opioid use. Plan: The claimant was scheduled for a left sympathetic nerve block at L3 under fluoroscopic guidance and IV sedation. He was given a refill prescription for hydrocodone 5/325 mg and Lyrica 75 mg.

May 9, 2011: The claimant had a follow-up evaluation by MD who noted it had been 3 days since he had a lumbar sympathetic block with Dr. and his pain level had improved by at least 50%. PE: The knee and leg felt warmer. He had full motion. He still was tender along the medial joint line. Stable knee with no overt instability noted. Recommendations: Dr. would like to proceed with his knee arthroscopy but under the cover of the sympathetic block. A second sympathetic block would be scheduled in six weeks and within a few days of the block the diagnostic arthroscopy to evaluate the knee.

May 11, 2011: The claimant had a follow-up evaluation by MD. PE: Allodynia and hyperesthesia were diminished. Plan: Submit for a left L3 lumbar sympathetic block under fluoroscopy guidance and IV sedation.

June 9, 2011: The claimant had a follow-up evaluation by MD who noted the epidural block to be done as coverage during surgery has been denied. Recommendations: Dr. recommended scheduling knee surgery on the 23<sup>rd</sup> and a sympathetic block completed by Dr. on the 22<sup>nd</sup>. Dr. stated the two things need to happen together as he is not going to do the knee scope unless the claimant is under the protection of the sympathetic block.

July 13, 2011: M.D. performed an UR on the claimant.

July 21, 2011: The claimant had a follow-up evaluation by MD. It was noted that the claimant was scheduled for a sympathetic block with Dr. on the 26<sup>th</sup> and the arthroscopic knee surgery on the 28<sup>th</sup>. Apparently, this was being denied by the insurer because they felt it was not related to the claimant's work injury

August 8, 2011: M.D. performed an UR on the claimant.

### **PATIENT CLINICAL HISTORY:**

The claimant was injured on xx/xx/xxxx while *carrying* approximately 30 pounds and he lost his balance. His leg then became stuck and his body twisted to the left, at which time he felt a pop in his left knee.

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

The previous decisions are upheld. There is no documentation of joint swelling, no documentation of joint locking, clicking, or popping, ROM is full, and the MRI on November 23, 2010 was negative for a meniscus tear. The claimant does not meet the criteria per the ODG for surgical intervention.

### **ODG:**

#### **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).

#### **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

[\(Washington, 2003\)](#) [\(Hunt, 2002\)](#) [\(Janecki, 1998\)](#)

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

**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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)