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### Notice of Independent Review Decision

**Date notice sent to all parties:** 07/31/12

**IRO CASE #:**

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

Right knee arthroscopy with meniscal debridement chondroplasty and possible lateral release

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

Board Certified in Orthopedic Surgery

**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 medical necessity exists for each of the health care services in dispute.

Right knee arthroscopy with meniscal debridement chondroplasty and possible lateral release - Upheld

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

On 01/19/12, Dr. evaluated the claimant. It was noted Dr. had recently suggested hardware removal and arthroscopic debridement. The claimant inquired about hyaluronic acid injections. Valgus orientation was noted on exam and there was no appreciable effusion. Extension was full and flexion was 135 degrees. The claimant wanted to postpone surgery as long as possible and hyaluronic injections were recommended. Dr. provided Euflexxa injections on 02/01/12, 02/08/12, and 02/15/12. On 05/10/12, the claimant noted more mechanical symptoms and the last set of injections did not provide appreciable relief. Arthroscopic examination of the right knee with meniscal debridement chondroplasty and possible lateral release was recommended. On 05/30/12, D.O., an orthopedic surgeon on behalf of Sedgwick CMS, provided a letter of non-authorization for the requested surgical

procedure. On 06/14/12, Dr. documented a positive McMurray's testing for lateral compartment pain. He was tender along the medial joint line with 1+ effusion. Extension was full and flexion was 130 degrees. It was noted they would appeal the denial for the right knee surgery. On 07/03/12, M.D., an orthopedic surgeon also on behalf of xxxxx, also provided a letter of non-authorization for the requested right knee arthroscopic meniscal debridement chondroplasty and possible lateral release. On 07/17/12, Dr. noted the claimant had received extensive conservative care and was exercising on a regular basis. He was able to fully extend the knee and flexion was 125 degrees. McMurray's and apprehension testing was noted to be positive. It was noted the claimant would request an IRO.

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

The claimant is a male whose past medical history is significant for a prior knee arthroscopic procedure, which was subsequently followed by a right high tibial osteotomy. The treating provider has reported physical findings consistent with advanced arthritic disease. In fact, orthopedic literature notes that high tibial osteotomy may be of benefit in patients with unicompartmental degenerative disease. The objectively documented physical findings in the medical records reviewed show, at this time, that the claimant has at least two compartmental arthroses. It documents an excellent range of motion, being from 0° to 130°.

The evidence based ODG criteria for arthroscopy and meniscectomy include the following:

- 1) Conservative care; physical therapy or medication or activity modification, plus
- 2) Subjective clinical findings (at least two); Joint pain or swelling or feeling of giving way or locking or popping, plus
- 3) Objective clinical findings (at least 2); Positive McMurray's sign or joint line tenderness or effusion or limited range of motion or locking or clicking or popping or crepitus, plus
- 4) Imaging clinical findings; Meniscal tear on MRI (Washington 2003).

A knee arthroscopy is not recommended for osteoarthritis in the absence of meniscal findings. It should be noted that arthroscopic debridement of meniscus tears in knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for all patients with knee arthritis (Siparsky, 2007). Arthroscopic surgery for knee arthritis offers no added benefit to optimize physical and medical therapy according to the results of a single-center randomized clinical trial 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, it 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.

The ODG indications for chondroplasty include the following: Shaving or debridement of articular surface requiring all 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) (Janecky 1998).

The ODG indications for lateral retinacular release include the following:

- 1) Conservative care, physical therapy (not required for acute patellar dislocations with associated intra-articular fracture) or medications, plus
- 2) Subjective clinical findings; knee pain with sitting or pain with patellofemoral 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 greater than 15°, plus
- 4) Imaging clinical findings; abnormal patellar tilt on x-ray, computed tomography, or MRI (Washington, 2003) (Fithian, 2004) (Aberinto, 2002) (Naranja, 1996) (Radin, 1993).

The claimant's primary symptoms appear to be the result of arthrosis as documented by the crepitus on clinical examination and the presence of an effusion. Viscosupplementation was performed, which is only approved by the FDA for the diagnosis of osteoarthritis which has failed to respond to conservative treatment. The requested procedure was denied on initial review and the denial was upheld on reconsideration/appeal. Both reviewers cited the reason for denial as the lack of the requested procedure meeting the criteria as outlined by the evidence based ODG. The requested procedure does not meet the criteria as outlined by the ODG. A repeat arthroscopy in the setting of advanced arthrosis is not supported by the current orthopedic scientific literature, or the evidence based ODG. It should be noted that in addition, the claimant does not meet the criteria for lateral retinacular release and the lack of documenting of abnormal patellar tilt on x-ray computer tomography or MRI. Therefore, the requested right knee arthroscopy with meniscal debridement chondroplasty and possible lateral release is not appropriate and the previous adverse determinations should be upheld at this time.

**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)  
*New England Journal of Medicine*