

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: December 5, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

29879 Left Knee Abrasion Chondroplasty

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

This physician is Board Certified in Orthopaedic Surgery with over 13 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

11-30-12: Office Visit

11-30-12: Knee 4 Views – Left

12-06-12: Office Note

12-14-12: MRI L WR EXT any joint W/O contrast

01-16-13: Office Visit

02-04-13: Operative Report

02-19-13: Follow up Visit

03-12-13: Knee, One or Two Views – Left

03-20-13: Follow up Visit

04-04-13: Initial Evaluation

04-25-13: Follow up Visit

04-25-13: Clinic Note

06-12-13: Follow up Visit

06-20-13: Plan of Care

06-25-13: Discharge Summary
07-18-13: MRI L WR EXT any Joint W/O Contrast – Left
07-25-13: Follow up Visit
07-25-13: Follow up
08-15-13: Office Note
09-26-13: Follow up Visit
09-26-13: Follow up Visit
10-02-13: Request for Pre-authorization
10-07-13: UR performed
10-14-13: Request for Appeal
10-21-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx while at work when she kind of twisted and fell and landed on the anterior aspect of her knee. She suffered some bruising and pretty immediate swelling. Since that point she has had to go back to work with brace, light duty. She complained of left knee giving out secondary to pain and swelling. She has had previous scope of left knee done in 2003, 2005, and 2006, partial meniscectomies on the left knee.

11-30-12: Office Visit. Claimant reported constant pain to her left knee that increases with walking or standing, and improves with rest. She has swelling to the knee and reported that it gives out on her daily, however no complaints of locking. She has some numbness to the anterior knee, but no other motor sensory deficits. Claimant reported that her surgery was denied and is appealing the decision. Current medications: ibuprofen and Vicodin. PE: Claimant ambulates with minimally antalgic gait with no assistive devices. Left Lower Extremity: Reveals she has tenderness noted to the junction of the middle and distal thirds anteriorly of the thigh extending to the knee. There is no tenderness, erythema, or edema noted to the thigh. Knee: Reveals she has tenderness to the medial and lateral surfaces including the medial and lateral joint lines. There is minimal edema, but (incomplete record).

11-30-12: Knee 4 Views – Left dictated. Impression: No acute osseous abnormality identified.

12-06-12: Office Note dictated. Narrative: The claimant seen today. Concur with his diagnosis and treatment plan. Impression: Contusion, left knee,

12-14-12: MRI L WR EXT any joint W/O contrast. Impression: 1. Postoperative medial meniscus, as described. 2. Free edge tearing at the junction of the posterior horn and body of the lateral meniscus with small radial component.

01-16-13: Office Visit. Claimant complained of left knee pain and swelling. PE: Left Knee: She has 1+ effusion. She goes 10 to about 90. She has no medial or lateral laxity. She has tenderness medially and laterally with a positive McMurray's medially and laterally. X-Rays: Plain x-rays show some mild medial compartment and patellofemoral DJD. No other significant bony abnormalities.

MRI looks like she now has a new undersurface medial meniscus tear and maybe small radial tear of lateral meniscus and some DJD. Impression: Torn meniscus and degenerative joint disease. Plan: Discussed benefits of arthroscopy, permits signed. If, however, it is more arthritic in nature, she may or may not get as much benefit and then possibly starting to think about entertaining a knee replacement would be a better choice.

02-04-13: Operative Report. Preoperative Diagnosis: Medial meniscus tear, left. Postoperative Diagnosis: Medial meniscus tear, left.

02-19-13: Follow up Visit. Claimant reported today postop left knee – arthroscopic surgery and knee – partial medial meniscotomy/arthroscopic. Wounds are clean and dry, sutures removed. Claimant was given instructions concerning rehab – stationary bike and SLR's. Follow-up in one month.

03-12-13: Knee, One or Two Views – Left. Impression: No definite acute osseous finding.

03-20-13: Follow up. Claimant presented with minimal knee pain, significant leg weakness from a standpoint, difficulty getting out of a chair. She is only riding a bike 5-10 minutes a day or maybe every other day and only doing 15-20 leg lifts. PE: She does not have any effusions and good ROM. Plan: Start outpatient physical therapy program. Told her realistically with leg lifts, she probably needs to be doing 200-300 per day and really needs to be on the bike 30-45 minutes daily. She will start outpatient PT and follow up in 6 weeks.

04-04-13: Initial Evaluation. Diagnoses: 71789 Int derangement knee nec, V5489 orthopedic aftercare nec, 71946 joint pain-L/leg, 71956 joint stiffness nec-L/leg, 72887 muscle weakness-general. Subjective Examination: ADL/Functional Status: Current status: work status: unable to work secondary to dysfunction. Basic care: has to go up one step at a time, cannot squat or kneel. Can stand 15-30 minutes before pain increases. Pre-morbid status: work status: full time/full duty. Basic care: independent without difficulty. Occupation: job title: floor manager at Salvation Army. Chief complaint: Pain: Current severity: 6/10; severity at worst: 8/10; severity at best: 2/10. Aggravating factors: when she is up on her leg for prolonged periods of time. KOS score is 26.25%. Rehabilitation expectations/goals: be able to go back to work and regain her strength. Assessment: The claimant requires skilled physical therapy to address the problems identified, and to achieve the individualized patient goals as outlined in this evaluation. Overall rehabilitation potential is good. The expected length of this episode of skilled therapy services required to address the claimant's condition is estimated to be 6 weeks. The claimant was educated regarding their diagnosis, prognosis, related pathology & plan of care. Presentation: symptoms consistent with referring diagnosis. Displays signs and symptoms of: Knee: Osteoarthritis. Moderate Limitations In: ROM due to: localized pain, weakness. Moderate limitations in: muscular performance due to: weakness, localized pain, pathology / condition. Recommendations: skilled intervention: required to: decrease pain, improve balance, increase ROM, increase strength, return to pre-

morbid state, and return to work. Treatment emphasis to focus on: controlling and normalizing: pain, muscle function improvements, ROM / mobility improvements, enhanced dynamic stability, strength disuse components, and maintain fitness. Plan: Frequency and duration: it is recommended that the claimant attend rehabilitative therapy for 2 visits per week with an expected duration of 3 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified. Therapeutic contents: active assistive ROM activities, aerobic conditioning: recumbent bicycle, stairstepper and treadmill.

04-25-13: Follow up Visit. Claimant presented with not having too much pain, however, somehow the workers' comp dropped the ball on therapy, so she has only had one session in the past month, and therefore complained of her leg feeling remarkably weak. On exam, good ROM and no effusions, noted significant decreased quad strength. Plan: Neoprene hinged brace to help support knee a little better due to feeling like she might fall. Follow up in 2 months.

06-12-13: Follow up Visit. Claimant presented with left knee pain 5-6/10, wearing brace and stated that it has helped. She has completed a couple of therapy sessions which helped a little bit. PE: Claimant has fairly good ROM, knid of tenderness medially and laterally. Impression: S/P arthroscopy without significant relief yet. Plan: Recommend to get a follow up MRI.

06-20-13: Plan of Care. Assessment: The claimant has met 53% of goals. Recommendations: Skilled intervention: required to: will finish up final visit, to make sure claimant has good understanding of HEP, no follow up required. Plan: Will complete final visit and then discharged to f/u for another MRI. Therapeutic contents: AROM activities, HEP, joint mobilization techniques, self care/home management, stretching/flexibility activities, therapeutic activities. Modalities: cryotherapy, ice massage. Resistive activities: isotonic, machine/free weights, total gym.

06-25-13: Discharge Summary. Diagnoses: 71789 Int derangement knee nec, V5489 orthopedic aftercare nec, 71946 joint pain-L/leg, 71956 joint stiffness nec-L/leg, 72887 muscle weakness-general. Objective Examination: Functional Tests: claimant is not able to walk on heels, is able to walk on toes and not able to kneel at this time. She can only squat ¼ range... 4/30/13 able to lift but felt unstable and had some discomfort...5/21/13 is able to lift 40# but it was the max. Palpation: Bony Structures: Tenderness: lateral joint line: left: 2=pain with wincing; medial joint line: left: 2=pain with wincing. Assessment: Based on the claimant's clinical presentation, the claimant's prognosis at time of discharge is fair. The claimant was educated regarding their discharge prognosis and related pathology. The claimant demonstrates excellent understanding of the HEP instructions. At this time skilled rehabilitative services at this site are no longer required due to the claimant's plateau in progress. Recommendations: Discharge, Secondary to: completion of current program, plateaued progress, and requiring further alternative treatment. Plan: discharge from PT, discharge to

independent HEP. Discharged due to: completed current program, program has plateaued. Claimant has been seen for a total of 18 visits and her progress has plateau and further therapy is not recommended at this time.

07-18-13: MRI L WR EXT any Joint W/O Contrast – Left. Impression: 1. Slight progression of a small lateral meniscal tear as above. 2. Postoperative findings from multiple prior and interval medial meniscectomies without new tear medially.

07-25-13: Follow up Visit. Claimant's status is unchanged, complained of intermittent pain to her left knee, increased with prolonged sitting, standing or walking. IT does improve with changing positions. She stated that the left leg feels weak, denied locking or buckling. PE: claimant ambulates independently with an analgic gait. No further examination completed. Claimant was given a temporary handicapped parking pass to obtain at the local driver's license plate agency. Clinical Impression/diagnosis: Left knee pain in a patient status post partial medial meniscectomy, 02/04/13. Plan: 1. The claimant will be continued off work, 2. RTC 6 weeks.

07-25-13: Follow up. Claimant complained of severe medial and lateral knee pain, a kind of diffusely, painful to touch. PE: Fairly good ROM, wearing a brace, stated it helped some. MRI was reviewed, she might have a very, very small undersurface lateral meniscus tear, and would read this as more degenerative area, medial side and do not see a discrete meniscus tear. Impression: Osteoarthritis symptoms. Plan: set up a Synvisc injection and return in 4-6 weeks.

08-15-13: Office Note. Synvisc-One injection performed. Return in 6 weeks.

09-26-13: Follow up Visit. Claimant stated that the injection helped some with the tightness and swelling, but still has the feeling like it wants to give way. She has attempted to work out on it, however cannot do much. PE: She has no effusion and good ROM. Impression: Kind of some degenerative joint disease. Plan: recommend scope, permit signed.

09-26-13: Follow up Visit. Claimant continued to have significant pain to her left knee, with knee giving out daily; it has not locked. She has swelling to the knee. The claimant stated the Synvisc did not help with her pain. Currently taking Vicodin as needed. Claimant requested to rewrite temporary handicapped parking due to grandchild tearing up the previous one. PE: no acute distress. Clinical Impression/Diagnosis: Left knee pain in a patient status post partial medial meniscectomy, 02/04/13. Plan: 1. The claimant will be continued off work, 2. RTC 6-8 weeks.

10-02-13: Request for Pre-authorization. Requested services: 29879 Left knee abrasion chondroplasty, 40 minutes.

10-07-13: UR performed. Reason for denial: The claimant is a female who reported an occupational incident on xx/xx/xx when she tripped and fell forward

and her left knee struck the floor. Reported treatment for diagnosed left knee pain has included viscosupplementation injection, Vicodin prn, brace, PT; she underwent left knee arthroscopy and partial medial meniscectomy on 02/04/13 and the operative report documents unremarkable articular cartilage in all 3 compartments, and an MRI has shown evidence of multiple medial meniscectomies. X-rays of the left knee on 3/2/13 were reported by the radiologist showed no definite acute osseous finding. An MRI on 7/18/13 showed slight progression of a small lateral meniscus tear and postoperative findings of multiple prior and interval medial meniscectomy is without a new tear medially; it was interpreted by another physician on 7/25/13 as showing a very small undersurface lateral meniscus tear or degenerative area without a discrete meniscus tear. On 9/26/13 she reported to 2 physicians that an injection helped the tightness and swelling of her knee but complained of feeling of impending giving way., no locking; pertinent physical findings included antalgic gait without assistive device, no effusion, good ROM; one physician diagnosed "kind of some degenerative joint disease", and the physician recommended arthroscopy. Applicable clinical practice guidelines support chondroplasty to treat chondral defects demonstrated by MRI when knee pain and swelling and effusion or crepitant range of motion persist despite treatment, and guidelines do not recommend chondroplasty as treatment for degenerative arthritis. This individual has persistent knee pain after she tripped and hit her left knee less than a year ago and treatment included medications and injections and PT, and there is evidence that she has undergone multiple medial meniscectomies, and at a meniscectomy procedure about 8 months ago she was found to have unremarkable articular cartilage in all 3 compartments of her knee, and a recent MRI showed some abnormality of the lateral meniscus interpreted by the treating physician as a degenerative signal but no report of chondral defect, so the medical necessity for left knee chondroplasty is not clearly demonstrated.

10-21-13: UR performed. Reason for denial: The claimant reported an injury on xx/xx/xx and she is status post arthroscopic partial medial meniscectomy of the LEFT knee on 2/4/13. On 7/18/13, an MRI of the LEFT knee noted slight progression of a small lateral meniscal tear and postoperative findings from the medial meniscectomy. The patellar cartilage and medial lateral articular compartment cartilage was unremarkable. On 7/25/13, the treating provider noted continued pain and recommended Viscosupplementation. On 9/26/13 in follow-up, the claimant had continued significant pain and a repeat arthroscopic surgery was recommended, as the claimant reported the knee giving out daily with swelling. The Synvisc did not help. On 10/11/13, the claimant reported constant LEFT knee pain with objective findings of tenderness at the junction of the medial distal thirds of the thigh with knee tenderness medial and lateral joint lines with minimal edema. The ODG guidelines require that the claimant must have a chondral defect on MRI. The MRI performed 7/18/13 showed no evidence of osteochondral lesions or other chondral defect. Therefore, the requested chondroplasty is not medically necessary and is not certified.

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

Previous adverse determinations are upheld and agreed with. The Official Disability Guidelines (ODG) requires the patient to have a chondral defect on MRI prior to consideration for arthroscopic chondroplasty. The MRI studies of 12/14/12 and 7/18/2013 do not indicate any articular cartilage defects. Furthermore, the left knee arthroscopy performed on 2/4/2013 did not identify any cartilage lesions that would require further treatment. The only pathology identified at the time of surgery was the medial meniscus tear. Based on the medical records reviewed, there is no arthritic lesion in the left knee that would require chondroplasty. Abrasion chondroplasty is not medically necessary for this patient. After review of the medical records and documentation provided, the request for 29879 Left Knee Abrasion Chondroplasty is denied.

Per ODG:

Chondroplasty	<p>ODG Indications for Surgery™ -- Chondroplasty: Criteria for chondroplasty (shaving or debridement of an articular surface), requiring ALL of the following:</p> <ol style="list-style-type: none"> 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) <p>For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</p>
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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)