

Notice of Independent Review Decision

**September 16, 2013**

**IRO CASE #:**

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

29880 Knee Authroscopy/Menisectomy : 29888 Arthroscopic ACL Repair/Augmentation/Recon

**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 Orthopedic Surgery. The physician has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

**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.

*Upon independent review, I find the previous adverse determination should be overturned.*

*Utilizing the Official Disability Guidelines for both ACL reconstruction and meniscectomy, it appears that the documentation available to review in this file meets or exceeds the ODG indications for these surgeries.*

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

Records Received: 15 page fax 08/27/13 Department of Insurance IRO request, 34 pages of documents received via fax on 08/27/13 URA response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx (DOI) to 08/27/13.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Reportedly injured xx/xx/xx following an activity. There was an immediate onset of pain. The patient reported a pop upon impact. There have been findings of positive pivot shift test along with tenderness to the medial joint line, swelling and effusion, and restricted range of motion. The patient underwent a period of physical therapy and home exercise with improving range of motion but continued to have disability, feelings of instability and locking of the knee.

Imaging studies revealed evidence for complete tear of the anterior cruciate ligament. Degenerative changes also are seen of the medial meniscus.

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

ODG indications for surgical meniscectomy include a period of conservative care, appropriate subjective clinical findings, appropriate objective clinical findings, and imaging clinical findings. Medical records indicate that all of these have been met with the one exception of the imaging finding, which failed to show a frank tear of the medial meniscus. This patient's range of motion is markedly restricted, and certainly a case could be made that the patient does, in fact, have a locked or blocked knee.

With regard to the anterior cruciate ligament reconstruction, the indications for surgery there are similar. In this particular case, the imaging studies do document an ACL disruption.

**ODG -TWC**

*ODG Treatment*

*Integrated Treatment/Disability Duration Guidelines*

**Knee & Leg (Acute & Chronic)**

Anterior cruciate ligament (ACL) reconstruction	Recommended as indicated below. An examination of all studies that compared operative and conservative treatment of anterior cruciate ligament (ACL) rupture found that outcomes in the operative groups were generally better than in the conservative groups for younger patients, but outcomes are worse in older patients (age beyond 50-60 years). ( <a href="#">Hinterwimmer, 2003</a> ) ( <a href="#">Linko-Cochrane, 2005</a> ) Morbidity is lower for hamstring autografts than for patellar tendon autografts used for ACL reconstruction. ( <a href="#">Biau, 2006</a> ) The use of bracing after anterior cruciate ligament (ACL) reconstruction cannot be rationalized by evidence of improved
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	<p>outcome including measurements of pain, range of motion, graft stability, or protection from injury. (<a href="#">Wright, 2007</a>) Most of the roughly 100,000 ACL reconstructions performed each year are for younger patients. Although age has been considered a relative contraindication for ACL surgery in the past, active older patients may respond well to this surgery and should not be ruled out as surgical candidates based solely on their age. It is important to look at their comorbidities, e.g., malalignment and osteoarthritis, because they predict potential problems. (<a href="#">Wulf, 2008</a>) Anterior cruciate ligament (ACL) reconstruction using an allograft has a high failure rate in young, active adults. While there are obvious benefits of using the cadaver ligament, like avoiding a second surgical site on the patient, a quicker return to work and less postoperative pain, for the young patient who is very active, it may not be the right choice. (<a href="#">Luber, 2008</a>) In patients with ACL injury willing to moderate activity level to avoid reinjury, initial treatment without ACL reconstruction should be considered. All ACL-injured patients need to begin knee-specialized physical therapy early (within a week) after the ACL injury to learn more about the injury, to lower the activity level while performing neuromuscular training to restore the functional stability, and as far as possible avoid further giving-way or re-injuries in the same or the other knee, irrespectively if ACL is reconstructed or not. (<a href="#">Neuman, 2008</a>) Patients with anterior cruciate ligament (ACL) injuries may not need surgery. At 2-5 years after injury, muscle strength and function were similar in patients treated with physical therapy and surgical reconstruction or physical therapy only. ACL injuries are associated with the development of osteoarthritis (OA) in the long term, and there is no evidence to suggest that reconstruction of the ACL prevents or reduces the rate of early-onset OA. On the contrary, the prevalence of OA may be even higher in patients with reconstructed ACL than in those with nonreconstructed ACL. (<a href="#">Ageberg, 2008</a>) Immediate surgical reconstruction may not be needed for ACL tears, according to the results of an RCT in the <i>New England Journal of Medicine</i>. Some patients who are not elite athletes can function with an ACL-deficient knee, but it is difficult to predict which patients will have symptoms of instability that require surgery. (<a href="#">Frobell, 2010</a>) Young athletes who need ACL reconstruction have better long-term outcomes with autologous grafts (self donor) versus allograft (cadaver). Patients who had ACL allograft reconstruction were almost seven times as likely to need a second surgery compared to autograft reconstruction. (<a href="#">Pallis, 2012</a>)</p> <p><b><u>ODG Indications for Surgery™ -- Anterior cruciate ligament (ACL) reconstruction:</u></b></p> <p><b>1. Conservative Care:</b> (This step not required for acute injury with hemarthrosis.) Physical therapy. OR Brace. PLUS</p> <p><b>2. Subjective Clinical Findings:</b> Pain alone is not an indication for surgery. Instability of the knee, described as "buckling or give way". OR Significant effusion at the time of injury. OR Description of injury indicates rotary twisting or hyperextension incident. PLUS</p> <p><b>3. Objective Clinical Findings (in order of preference):</b> Positive <a href="#">Lachman's sign</a>. OR Positive <a href="#">pivot shift</a>. OR (optional) Positive <a href="#">KT 1000</a> (&gt;3-5 mm = +1, &gt;5-7 mm = + 2, &gt;7 mm = +3). PLUS</p> <p><b>4. Imaging Clinical Findings:</b> (Not required if acute effusion, hemarthrosis, and instability; or documented history of effusion, hemarthrosis, and instability.) Required for ACL disruption on: Magnetic resonance imaging (MRI). OR Arthroscopy OR Arthrogram. (<a href="#">Washington, 2003</a>) (<a href="#">Woo, 2000</a>) (<a href="#">Shelbourne, 2000</a>) (<a href="#">Millett, 2004</a>) For average hospital LOS if criteria are met, see <a href="#">Hospital length of stay</a> (LOS).</p>
Meniscectomy	<p>Recommended as indicated below for symptomatic meniscal tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings. (<a href="#">Kirkley, 2008</a>) Meniscectomy is a surgical procedure associated with a high risk of knee osteoarthritis (OA). One study concludes that the long-term outcome of meniscal injury and surgery appears to be</p>

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determined largely by the type of meniscal tear, and that a partial meniscectomy may have better long-term results than a subtotal meniscectomy for a degenerative tear. ([Englund, 2001](#)) Another study concludes that partial meniscectomy may allow a slightly enhanced recovery rate as well as a potentially improved overall functional outcome including better knee stability in the long term compared with total meniscectomy. ([Howell-Cochrane, 2002](#)) The following characteristics were associated with a surgeon's judgment that a patient would likely benefit from knee surgery: a history of sports-related trauma, low functional status, limited knee flexion or extension, medial or lateral knee joint line tenderness, a click or pain noted with the McMurray test, and a positive Lachmann or anterior drawer test. ([Solomon, 2004](#)) Our conclusion is that operative treatment with complete repair of all torn structures produces the best overall knee function with better knee stability and patient satisfaction. 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 will not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis, and meniscectomy will not improve the OA. Meniscal repair is much more complicated than meniscal excision (meniscectomy). Some surgeons state in an operative report that they performed a meniscal repair when they may really mean a meniscectomy. A meniscus repair is a surgical procedure done to repair the damaged meniscus. This procedure can restore the normal anatomy of the knee, and has a better long-term prognosis when successful. However, the meniscus repair is a more significant surgery, the recovery is longer, and, because of limited blood supply to the meniscus, it is not always possible. A meniscectomy is a procedure to remove the torn portion of the meniscus. This procedure is far more commonly performed than a meniscus repair. Most meniscus tears cannot be treated by a repair. See also [Meniscal allograft transplantation](#). ([Harner, 2004](#)) ([Graf, 2004](#)) ([Wong, 2004](#)) ([Solomon-JAMA, 2001](#)) ([Chatain, 2003](#)) ([Chatain-Robinson, 2001](#)) ([Englund, 2004](#)) ([Englund, 2003](#)) ([Menetrey, 2002](#)) ([Pearse, 2003](#)) ([Roos, 2000](#)) ([Roos, 2001](#)) Arthroscopic debridement of meniscus tears and knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for all patients with knee osteoarthritis. ([Siparsky, 2007](#)) Asymptomatic meniscal tears are common in older adults, based on studying MRI scans of the right knee of 991 randomly selected, ambulatory subjects. Incidental meniscal findings on MRI of the knee are common in the general population and increase with increasing age. Identifying a tear in a person with knee pain does not mean that the tear is the cause of the pain. ([Englund, 2008](#)) Arthroscopic meniscal repair results in good clinical and anatomic outcomes. ([Pujol, 2008](#)) Whether or not meniscal surgery is performed, meniscal tears in the knee increase the risk of developing osteoarthritis in middle age and elderly patients, and individuals with meniscal tear were 5.7 times more likely to develop knee osteoarthritis. ([Englund, 2009](#)) AHRQ Comparative Effectiveness Research concluded that arthroscopic lavage for osteoarthritis, with or without debridement, does not improve pain and function for people with OA of the knee. ([AHRQ, 2011](#)) The repair of meniscal tears is significantly improved when performed in conjunction with ACL reconstruction. ([Wasserstein, 2011](#))

*Physical therapy vs. surgery:* In older patients with degenerative tears and symptoms caused by osteoarthritis, PT/exercise may be an appropriate first option and it may be possible to reserve surgery for those who do not benefit from PT alone. A high quality RCT, the Meniscal Tear in Osteoarthritis Research (METEOR) trial, found similar outcomes from PT versus surgery for meniscal tears in older individuals. Researchers at seven major universities and orthopedic surgery centers around the U.S. assigned 351 people with arthritis and meniscus tears to get either surgery or physical therapy, nine sessions on average plus exercises to do at home. After six months, both groups had similar rates of functional improvement, and pain scores were also similar. While 30% of patients assigned to physical therapy wound up having surgery before the six months was up, often because they felt therapy wasn't helping them, they ended up the same as those who got surgery right away, as well as the rest of the physical therapy group who stuck

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with it and avoided having an operation. These results suggest that physical therapy may be an appropriate first option for many patients with osteoarthritis and meniscal tears and that it may be possible to reserve surgery for those who do not benefit from physical therapy alone. ([Katz, 2013](#)) Arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical and medical therapy, according to the results of a single-center, RCT 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 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. ([Kirkley, 2008](#)) In this RCT, arthroscopic partial medial meniscectomy followed by supervised exercise was not superior to supervised exercise alone in terms of reduced knee pain, improved knee function and improved quality of life, after non-traumatic degenerative medial meniscal tear in ninety patients, mean age 56 years. ([Herrlin, 2007](#)) See also [Arthroscopic surgery for osteoarthritis](#).

## **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). Physiologically younger and more active patients with traumatic injuries and mechanical symptoms (locking, blocking, catching, etc.) should undergo arthroscopy without PT.

**1. Conservative Care:** (Not required for locked/blocked knee.) Exercise/Physical therapy (supervised PT and/or home rehab exercises, if compliance is adequate). AND (Medication. OR Activity modification [eg, crutches and/or immobilizer].) 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 (order MRI only after above criteria are met). ([Washington, 2003](#))

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

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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)