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Notice of Independent Review Decision

IRO REVIEWER REPORT TEMPLATE – WCN

March 12, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient surgery left knee partial medial meniscectomy

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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:

- Diagnostics (08/14/12, 01/09/13)
- Office visits (09/06/12 - 01/15/13)
- Operative report (10/01/12)
- Physical therapy reports (10/04/12 – 12/03/12)
- Utilization reviews (01/28/13, 02/07/13)

- Office visits (07/30/12 – 02/01/13)
- DWC-73 (07/30/12 – 02/01/13)

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- Diagnostics (08/14/12, 01/09/13)
- Operative report (10/01/12)
- Physical therapy reports (10/04/12 – 11/27/12)
- Utilization reviews (01/28/13, 02/07/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a employed who on xxxxxxxx, was playing volleyball and felt a pop in his left knee.

2012: On July 30, 2012, evaluated the patient for left knee complaints. He diagnosed sprain of unspecified site of knee and leg and transferred the case to Workman Comp case.

On August 13, 2012, noted that the patient's left knee was not much improved. His joint tended to lock and click. recommended magnetic resonance imaging (MRI) to rule out possible meniscal tear.

On August 14, 2012, MRI of the left knee showed chondromalacia patella of the lateral patellar facet, intrasubstance degeneration of the medial meniscus, body and posterior horn and horizontal tear of the body of the lateral meniscus and a small joint effusion.

On August 23, 2012, reviewed the MRI findings as showing internal derangement and ordered a knee brace stabilizer.

On September 6, 2012, evaluated the patient for left knee pain. He noted that the patient had medial joint line tenderness, popping and catching. Examination showed medial joint line tenderness, medial pain with McMurray's maneuver and medial pain with forced extension. He reviewed the MRI of the left knee that showed degenerative tears of the medial and lateral meniscus. He recommended left knee arthroscopy, partial medial and lateral meniscectomy.

On October 1, 2012, performed left knee arthroscopy with partial lateral meniscectomy.

From October 4, 2012, through November 27, 2012, the patient attended 13 sessions of physical therapy (PT) consisting of moist heat/ice,

ultrasound/phonophoresis, therapeutic exercises, home exercise program (HEP) and balance activities.

From October 23, 2012, through November 21, 2012 evaluated the patient and recommended continuing PT.

On November 28, 2012, noted the patient had completed PT. The patient reported that his knee still hurt some. Examination of the left knee showed swelling and tenderness. The patient was not able to extend left knee straight by 10 degrees. recommended starting light duty with restrictions and allowed the patient to drive.

On December 19, 2012 noted the patient was improving. He recommended activities as tolerated.

On December 21, 2012 noted the patient had improved somewhat. The patient's knee hurt while kneeling down. continued light duty restrictions.

2013: On January 2, 2013, noted the patient was having recurrent pain and mechanical symptoms as well as medial pain despite activity restrictions. Examination of the left knee showed limited range of motion (ROM), quite a bit of medial pain with forward flexion and extension and medial pain with McMurray's maneuver. recommended obtaining an MRI to assess the medial meniscus.

On January 4, 2013 noted the patient was waiting for MRI. He recommended continuing duty restrictions.

On January 9, 2013, MRI of the left knee showed unstable radial tear posterior horn medial meniscus, with gap of 2.8 mm right to left. There was myxoid degeneration of the lateral meniscus. There was tricompartmental chondromalacia most severe in the patellofemoral and medial femorotibial compartments. There was a large joint effusion. There was moderate Baker's cyst with evidence of leaking inferiorly.

On January 15, 2013 reviewed the MRI findings and recommended left knee arthroscopy and partial medial meniscectomy.

Per utilization review dated January 28, 2013, the request for an outpatient surgery left knee partial medial meniscectomy was denied an orthopedic surgeon, based on the following rationale: *"This male was injured on xxxxxx, while playing volleyball and landed the wrong way after going up for the ball. The patient injured the left knee twisting it and had subsequent swelling. Patient subsequently underwent medial lateral meniscectomy left knee on August 1, 2012, with 12 sessions of therapy authorized postoperatively. The patient had a repeat MRI on January 9, 2013, noting an unstable radial tear posterior horn medial meniscus with myxoid degeneration lateral meniscus, tricompartmental chondromalacia most severe in the patellofemoral medial compartments with a large joint effusion with moderate Baker's cyst. The January 15, 2013, report*

noted the patient having left knee pain and mechanical symptoms especially with bending and stooping. The physical examination reported knee somewhat guarded with medial joint line tenderness, medial pain with McMurray's. A left knee arthroscopy with partial medial meniscectomy was recommended due to continued mechanical symptoms. The more current symptoms occurred after the patient initially did well postoperatively during the rehabilitation phase and at this time with lack of any current documentation of conservative treatment, I recommend non-certification of the meniscectomy in line with ODG recommendations."

On February 1, 2013 noted that the orthopedic surgeon was having trouble with WC in getting the second surgery on knee approved. Examination of the left knee showed swelling, tenderness, ROM extension to flexion 0 to 45 degrees, inability to extend straight by 10 degrees, audible click with extension from flexion and peripatellar edema. noted the patient was not able to return to work due to exhaustion of light duty Workman Comp time. He was waiting for a second procedure.

Per utilization review dated February 3, 2013, reconsideration for outpatient surgery left knee partial medial meniscectomy was denied based on the following rationale: *"This claimant is a male who was playing volleyball on xxxxxx, when he came down wrong and injured his left knee. This caused some swelling. He was treated with medications and physical therapy (PT). His MRI on August 14, 2012, noted chondromalacia of the patella, intrasubstance degeneration of the medial meniscus, including the body and posterior horn and a horizontal tear of the lateral meniscus. In spite of these obvious degenerative changes, an arthroscopy was done on October 1, 2012, involving medial and lateral meniscectomies. At surgery, he had typical degenerative changes with medial tibia grade II changes, a complex tear of the lateral meniscus and a diffuse grade II chondromalacia of the tibia and femur. Postoperatively, he had stiffness at the first visit, pain and range of motion (ROM) of -5 to (-) 120; on the second visit, full ROM on December 19, 2012. On January 2, 2013, he had more pain and "mechanical symptoms" not further described. He had a repeat MRI that showed an "unstable" posterior horn of the medial meniscus, myxoid degenerative of the lateral meniscus, tricompartmental chondromalacia, a large effusion and a new Baker's cyst. There was a prior request for repeat arthroscopy with partial medial meniscectomy that was denied because there was no documentation of conservative care. For this appeal, there are clinical notes from January 15, 2013, and back with no discussion of conservative care and apparently no new information relative to the prior review."*

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

I reviewed the medical information and previous review. This patient has, in essence, a locked knee and unstable meniscus tear. However, the extent of degeneration in the knee is not clear as only an MRI was available for review and MRI can overcall chondromalacia changes within the compartments of the knee.

Additionally, there is not evidence of conservative care beyond that given in the immediate postoperative period of the initial surgical intervention. In the absence of information with respect to the extent of degenerative changes in the knee and with no indication of recent failed attempts at conservative care, I would uphold the determination; the requested surgery is not medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

Official Disability Guidelines, Treatment in Worker's Comp 18th edition, 2013 Updates – Knee Chapter

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- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES