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Notice of Independent Review Decision

IRO REVIEWER REPORT TEMPLATE –WC

February 3, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right knee arthroscopy with debridement and synovectomy

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:

Overturned (Disagree)

Medical documentation supports 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:

TDI

- Utilization reviews (11/16/12, 12/10/12)
- Diagnostics (03/24/01 – 07/27/11)
- Office visits (04/05/01 – 01/16/03)
- Procedures (06/07/01, 04/21/03, 12/01/03, 09/14/09)
- Office visits (05/05/04 - 11/07/12)

- Utilization review (11/16/2012)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who injured her right knee when she was walking and carrying a tray and twisted. She developed increased pain within the knee.

2001 – 2002: On March 24, 2001, magnetic resonance imaging (MRI) of the right knee showed a complex tear of the posterior horn of the medial meniscus, a tear of the anterior horn of the lateral meniscus and a small joint effusion. There was partial lateral subluxation of the patella. There were small decreased subchondral cysts in the tibia deep to the intercondylar notch. There was a degenerative cyst seen in the patella.

In April 2001, the patient was evaluated by an orthopedic surgeon, for persistent episodes of pain within the knee with episodes of pain when standing from a seated position as well as climbing the stairs. The patient was under the care of and had undergone an MRI which showed evidence of medial and lateral meniscus tears. Examination of the right knee showed palpable tenderness across the medial joint line with a positive McMurray's maneuver. assessed internal derangement and medial meniscus tear of the right knee, recommended arthroscopic evaluation with treatment. The patient was maintained on conservative treatment.

On June 7, 2001, performed comprehensive diagnostic arthroscopy of the right knee with arthroscopic partial medial meniscectomy, femoral chondroplasty medial femoral condyle; extensive synovectomy, femoral chondroplasty, medial femoral condyle, weightbearing surface and lateral patella facet arthroscopic lateral release.

On postoperative follow-up, noted the patient was recovering nicely with steady improvement. The patient was recommended physical therapy (PT) and was to continue rehabilitative exercises and strengthening.

From July 2001 through May 2002, the patient had several follow-ups. The patient had persistent swelling in her knee region and episodes of pain within her knee. She was noted to have postsurgical effusion which was recurrent. aspirated fluid and administered injection of steroid and local anesthetic on several occasions. He recommended wearing a knee brace, a knee sleeve and maintained the patient on conservative treatment with rehabilitative exercises and strengthening.

In May 2002, the patient had no effusion and was doing better.

In August 2002, the patient was seen who noted chronic that at the time of her surgery, she was found to have severe osteoarthritis of the weightbearing surface of the medial femoral condyle. She had recurrent effusion since then. She was seen for a second opinion and an MRI was repeated. assessed right knee effusion and osteoarthritis; aspirated about 70 cc of fluid and injected steroid and

local anesthetic injection. He opined that in the long term, the patient would require a medial compartment hemiarthroplasty or a proximal tibial osteotomy into valgus as the method of handling her knee.

In December 2002, noted the patient had constant pain and effusion in the right knee. Some palpable tenderness across the anterior aspect of the knee was noted with effusion. aspirated her knee and administered injection of Kenalog and Xylocaine.

2003: In March, noted that the patient had two second opinions and she was ready to proceed with surgery. He aspirated 80 cc of fluid from the right knee.

On April 21, 2003, performed right knee comprehensive diagnostic arthroscopy with arthroscopic partial medial and lateral meniscectomy, arthroscopic abrasion chondroplasty of the medial femoral condyle, arthroscopic chondroplasty and thermal chondroplasty of the lateral patella facet and extensive synovectomy. Postoperatively, recommended PT.

From May through July, the patient had several follow-ups for recurrent episodes of swelling and pain. The patient had tenderness of the knee. aspirated fluid from the right knee and administered injection of Kenalog and Xylocaine. The patient was recommended use of OA brace which helped her.

In July, noted that the patient had recurrent effusion. She had ballottement in the patella with effusion. He aspirated fluid from the right knee and administered injection of Kenalog and Xylocaine.

From September through October, administered five injections of Hyalgan. The patient was maintained on repetitive activities and strengthening.

In October, noted that the patient continued to suffer chronic knee effusion and chronic pain within her knee region. Her previous arthroscopy showed advanced degenerative changes within the knee. recommended total knee replacement (TKR).

On December 1, 2003, performed total right knee replacement. Postoperatively, noted that the patient was improving steadily.

2004: From January through October, the patient was under the care of. She was recovering steadily. She had occasional pain in the right knee and slight effusion. She felt much improved. She had episodes of some pain within her knee with difficulty. She was seen for warmth in the knee. She also had pain across the anterior aspect of the knee. aspirated fluid followed by administration of Kenalog and Xylocaine injection. The patient was treated conservatively and with Motrin. obtained a venous Doppler study which was noted to be negative.

In October, aspirated the patient's knee with return of 30 cc of blood-tinged synovial fluid and injected it with Kenalog and Xylocaine. He recommended GenuTrain knee sleeve.

2005: In March and August 2005, evaluated the patient for episodes of pain within the right knee with activities and episodes of swelling. assessed chronic internal derangement injury of the knee, prescribed Ultram and Relafen and recommended continuing rehabilitation. On follow-up in August 2005, aspirated 20 cc of blood-tinged synovial fluid and recommended use of BioSkin knee sleeve.

2006: In April, noted that the patient had some rotatory instability in the lateral part of the knee. He obtained x-rays which were suggestive of probable wear of the lateral tibial insert. He prescribed Ultram and Relafen and opined that the patient might require revision arthroplasty in the future.

In May, the patient felt much better after aspiration of the fluid from the knee. She had recovered nicely. She had little bit of medial laxity but not instability. recommended continuing activities of daily living (ADL).

In December, recommended use of Relafen and Ultram as the patient had episodes of pain due to cold weather.

2007: The patient was evaluated in July and December for burning sensation across the anterior aspect of the knee and episodes of instability. Examination showed slight varus-valgus laxity of the right knee, slight anterior-posterior laxity and slight pain at extremes of motion. X-rays of the right knee was suggestive of loosening of the tibial component and wear of the tibial tray plastic. recommended revision TKR.

In December, noted that the patient was still using brace because if she did not use the brace, the knee would wobble and give out. He opined that the patient was not ready for surgery and maintained her on Duragesic and Ultram.

2008: In May, noted that the patient continued to have recurrent episodes of effusion within her right TKR. He aspirated 20 mL of fluid and administered injection of Kenalog with Xylocaine and recommended conservative treatment.

2009: The patient was seen in July and August who noted some laxity medially and laterally and a positive drawer's sign. recommended proceeding with a revision of her TKR.

On September 14, 2009, performed revision of right TKR, tibial component. On discharge on September 17, 2009, the patient was recommended to continue home health, PT and rehabilitation with durable medical equipment (DME).

On postoperative follow-ups, noted that the patient was recovering nicely. The patient was doing her own PT. recommended continuing exercises at home.

In November, noted the patient had slight swelling over her right knee. He aspirated the fluid, injected the knee, and recommended continuing exercises, strength training and rehabilitation.

2010: In January and March, noted that the patient had some swelling in the inferior aspect of the patella as well as slight effusion in the knee. She also had slight pain with range of motion (ROM). She was overall doing well. aspirated 20 cc of serosanguineous fluid from the knee.

In July, the patient reported some increased levels of pain and discomfort within the knee and some swelling in her calf medially. Examination showed small lipoma in the calf and tenderness across the anterior aspect of the knee within the patella. assessed postoperative pain with lipoma of the calf, administered injection of Kenalog and Xylocaine and prescribed Lortab.

In December, noted the patient had occasional swelling and pain in the right knee. He aspirated the knee with a return of normal-appearing fluid and recommended continuing physical activities.

2011: In April, the patient reported feeling pressure in the right knee. Examination showed tenderness about the medial aspect. assessed effusion of the lower leg joint and prescribed Lortab.

In May, noted that the patient had a little pain on her right knee. Examination showed moderate effusion of the right knee. assessed broken prosthetic joint implant and opined that the joint was painful because of the accumulation of fluid. He aspirated the fluid and administered injection of Depo-Medrol.

In June, the patient reported worsening of symptoms with swelling and pain. She reported that if she bent the knee it would give out. Examination of the right knee showed large effusion (hemarthrosis). assessed broken prosthetic joint implant and effusion of the lower leg joint. The patient was exercising and had developed pain. performed fluid aspiration and administered injection of Depo-Medrol. He obtained x-rays of the right knee which showed no signs of loosening.

On July 6, 2011, noted that the patient had swelling and pain around the knee. He aspirated the fluid and administered injection of corticosteroid and local anesthetic and prescribed hinged knee sleeve. On follow-up, prescribed EC-Naprosyn and referred the patient for arteriogram and venogram of the right leg to look for the intra-articular bleed.

In August, noted that the patient had undergone a venogram. Examination of the right knee showed moderate effusion (only blood tinged). prescribed Plavix, recommended starting Penicillin V potassium and continuing EC Naprosyn.

From August 18, 2011, through November 3, 2011, the patient had several follow-ups. The patient reported that she had been to the store, and later on, she could

not walk at all. The following day, she went (ER) where she underwent ultrasound and was told that she had a Baker's cyst. aspirated fluid from the right knee and administered corticosteroid and local anesthetic injection.

On September 8, 2011, the patient reported that she was feeling much better. She had traces of effusion. maintained her on Lortab and referred her for evaluation and treatment.

On follow-up, noted that the patient had some pain walking long distances associated with a burning sensation. She was not working. prescribed Ultram and recommended follow-up as needed or in one or three months.

2012: In February, noted the patient had a lot of pain. She was not working. Examination showed moderate effusion of the right knee. administered corticosteroid and local anesthetic injection after aspiration. 60 cc of blood was aspirated.

In August, noted that the patient had pain and swelling. She had an ulcer and was told to discontinue EC-Naprosyn and to start Celebrex. Examination showed a moderate effusion of the right knee. assessed knee pain, broken prosthetic joint impact and effusion of the lower leg joint, prescribed Celebrex and obtained x-rays of the right knee which was normal without evidence of loosening.

On October 16, 2012, ultrasound of the right lower extremity showed right knee total arthroplasty. Anterior to the knee, there was a 5.2 x 1.3 x 4.1 cm simple fluid collection. Posterior to the knee, there was a 6.6 x 2.4 x 1.8 cm complex fluid collection.

On November 7, 2012, evaluated the patient for constant pain to the right knee and moderate swelling. The patient was utilizing medications for pain/swelling. The patient had been to rheumatologist, who had ordered MRI. The patient was utilizing Lortab and Celebrex. Examination of the right knee showed moderate effusion. recommended continuing Celebrex and Lortab and right knee arthroscopy with debridement and synovitis.

Per utilization review dated November 13, 2012, the request for right knee arthroscopy with debridement and synovectomy was denied with the following rationale: *"The Official Disability Guidelines Knee and Leg Chapter on diagnostic arthroscopy outline the criteria. In the claimant's case, there is no current imaging study demonstrating surgical pathology. The claimant's physical examination reveals no objective evidence of impairment or surgical pathology. The claimant's conservative treatment has included medications. Considering the fact that the examination showed a moderate effusion, there has been no documentation of a joint aspiration or cortisone injection which could be beneficial to synovitis and thus avoid surgical intervention with the risk of postoperative complications. Taking into consideration the above factors of the claimant's case where there has been insufficient conservative management, no objective evidence of impairment or surgical pathology on the physical examination, and no current*

imaging study demonstrating surgical pathology, the request for right knee arthroscopy with debridement and synovectomy cannot be considered medically necessary."

Per reconsideration review dated December 10, 2012, the request for right knee arthroscopy with debridement and synovectomy was denied with the following rationale: *"The request for an appeal for right knee arthroscopy with debridement and synovectomy is not certified. The request was previously noncertified on November 16, 2012, due to there being no current imaging demonstrating surgical pathology. The claimant's physical examination revealed no objective evidence impairment or surgical pathology. The claimant's conservative treatments have included medications. Considering the fact that examination showed a moderate effusion, there has been no documentation of a joint aspiration or cortisone injection which could be beneficial to synovitis and thus avoid surgical intervention with the risk of postoperative complications. Taking into consideration the above factors of the claimant's case where there has been insufficient conservative management, no objective evidence of impairment or surgical pathology on physical examination, and no current imaging study demonstrating surgical pathology, the request cannot be certified. There was no additional documentation provided for review for the appeal. The previous non-certification is supported as there is no diagnostic documentation that was provided for review that would show any type of pathology indicating the necessity for surgical intervention. Besides a moderate joint effusion, there are no other physical examination findings suggestive of any internal pathology. The guidelines indicate that conservative care must be completed plus subjective complaints of pain and functional limitations despite the conservative care and inconclusive imaging. There was no documentation that the claimant has currently undergone any type of conservative care to include physical therapy, home exercise program, and again there was no imaging provided for review that documented any internal derangement. It was noted that an MRI was ordered but it is unclear if that has been accomplished. Based upon the medical documentation available for review and the peer-reviewed evidenced-based guidelines, the request for an appeal for right knee arthroscopy with debridement and synovectomy is not medically supported."*

On January 9, 2013, noted that the patient continued to have pain and swelling in the right knee. Inspection and palpation of the right knee showed severe effusion (100 cc of hemarthrosis). recommended continuing Lortab and Celebrex. He administered injection of Depo-Medrol and Levaquin. He opined that the necessity of injection was to treat acute pain in the joint and referred the patient for a computerized tomography (CT) scan of the right knee. He opined that the surgery was medically necessary as the patient continued with recurrent bloody effusions and pain. The necessity of the surgery was to remove the hemorrhagic synovium and coagulate any bleeding; without surgery this patient will continue to suffer.

On January 16, 2013, opined that if the patient was denied treatment based on the ODG guideline, the patient would continue to suffer unnecessarily.

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

This is a very complex case of recurrent effusions after total knee revision. There are no imaging studies to suggest loosening. Examinations in the office do not suggest instability. He has appropriately aspirated the recurrent effusions, injected them, and used oral medications. Despite all of this, it does not appear that this has resolved.

Previous reviews seem to be focused on the fact that there is no “imaging study” demonstrating surgical pathology. The imaging studies demonstrating surgical pathology are not needed in the setting of a total knee with recurrent bloody effusions. The differential diagnosis includes synovitis, unrecognized loosening, and mid flexion instability.

The treating physician has clearly used time, activity modification, oral medications, aspiration, and injection in the management of this claimant’s symptoms all with no avail. At this time, a diagnostic arthroscopy with synovectomy would be appropriate. This allows the physician to examine the claimant under anesthesia as well. It is quite possible that the physician could pick up some level of instability, particularly mid flexion instability, which may be contributing to recurrent effusions, particularly the bloody effusions which have been documented.

Given the failure of what appears to be very thorough conservative care for these recurrent effusions, I would definitely recommend examination under anesthesia with diagnostic arthroscopy and at least limited synovectomy. Based on the presence of these recurrent effusions, it is quite probable that this claimant will require revision in the future as an acceptable result has not been obtained.

On final review, I believe that the medical documentation does support the necessity of the services in dispute. I would disagree with the prior evaluations.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES