

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 11, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy, Knee Diagnostic, with or without Synovial Biopsy (Separate Procedure)

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

This physician is Board Certified Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

12-18-12: MRI Knee Right WO Contrast at Imaging dictated

12-20-12: Workers Comp Sheet

01-03-13: Patient Information at Center completed

01-03-13: Office Visit dictated

01-09-13: EKG

01-09-13: Pre Admission Instructions

01-14-13: Medication Reconciliation Form

01-14-13: Allergy, Height & Weight Form

01-14-13: Cardiac Function Capacity Assessment

01-15-13: Standing Orders: Perioperative: Anesthesia, Day of Surgery

01-15-13: Disclosure and Consent Medical and Surgical Procedures

01-15-13: Registration Packet

01-15-13: Nurses Assessment Form

01-15-13: Operative Note
01-15-13: Anesthesia Record Patient Care Services
01-15-13: Surgical Case Record
01-15-13: PACU Record
01-15-13: Discharge Instructions
01-15-13: Orthopedic Post-operative Orders
01-22-13: Office Visit
02-14-13: Office Visit
02-28-13: Office Visit
03-14-13: Office Visit
03-28-13: MRI Knee Right W Contrast
04-01-13: Office Visit
05-06-13: Office Visit
05-14-13: UR performed
05-16-13: Letter of Appeal at Center
05-20-13: Receipt of Reconsideration
05-22-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured himself at work on xx/xx/xx when he was walking across a parking lot. After several steps getting out of a truck, he had significant pain with popping on the medial side of his knee. He had significant pain and swelling and was evaluated. He denies pain prior to injury.

12-18-12: MRI Knee Right WO Contrast dictated Impression: 1. Right knee nondisplaced and nondepressed subchondral fracture, likely insufficiency fracture, of the weight bearing medial femoral condyle with extensive surrounding marrow edema. There is no cyst formation at the base of the lesion to suggest the presence of instability and there is no loose body. Overlying articular cartilage appears normal. 2. Nondisplaced radial tear of the medial meniscus posterior root. 3. Small to moderate right knee effusions and mild superficial infrapatellar bursitis. 4. Mild patellar chondrosis. 5. Mild distal quadriceps tendinopathy without tear.

01-03-13: Office Visit dictated Chief complaint: right knee injury. He noted instability with significant walking and has to walk with a cane and has problems doing so. He has taken anti-inflammatories with minimal improvement and noted his knee swells whenever he walks. Current medications: pravastatin, Vimovo, hydrocodone, Cozaar and Celebrex. PE: Right knee: 1+ effusion. He walks with a significantly antalgic gait. Noted significant medial joint line pain, positive McMurray's and mild patellofemoral crepitus with pain. Noted full extension and flexion to 120 degrees. X-Rays of Right Knee: weight bearing AP, lateral, and sunrise views: decreased joint space in the medial compartment with some squaring of the femoral condyle and small osteophytes forming, some small osteophytes forming in the patellofemoral area. Assessment/Plan: The claimant has suffered an injury to his right knee resulting in subchondral insufficiency injury to his medial femoral condyle, as well as a radial tear of the posterior horn of the

medial meniscus. He is a great candidate to have knee arthroscopically evaluated for possible partial medial meniscectomy.

01-15-13: Operative Note. Preoperative Diagnosis: Internal derangement, right knee. Postoperative Diagnoses: 1. Right knee posterior horn medial meniscus tear, radial tear of the root ligament insertion. 2. Degenerative joint disease of the right knee including grade II chondromalacia of the medial tibial plateau, lateral tibial plateau, patella, and trochlea. Procedures Performed: 1. Right knee arthroscopy with partial lateral meniscectomy. 2. Chondroplasty of the medial tibial plateau, trochlea, and patella.

01-22-13: Office Visit. Chief complaint: right knee post-op. Claimant stated he is having some pain on the medial side of his knee, although it is different from what his preoperative status was. PE: The claimant's right knee shows no significant swelling, full extension and flexion to about 110 degrees with some apprehension, mild medial joint line pain. Assessment/Plan: Physical therapy. The claimant will not be able to work due to heavy requirements for three weeks, which he will be seen for re-evaluation. Script given for Talacen and for therapy.

02-14-13: Office Visit. Claimant presented with significant grade 2 arthritis of the undersurface of the patella and trochlear region. He has gone to physical therapy and complained of issues with the patellofemoral joint when he is doing some sit downs and stand-ups. He reported some mild swelling and is not currently taking any medications. PR: Right knee: noted trace effusion and patellofemoral pain. Assessment/Plan: Recommend that he avoid some activities at physical therapy that tend to bother him more; gave Celebrex samples; re-evaluate in two weeks for evaluation of return to work.

02-28-13: Office Visit. Claimant reported continued pain, particularly start-up pain, as well as peripatellar pain. He reported some catching and some moderate soft tissue swelling. PE: Right knee: noted significant patellofemoral pain with crepitus and a trace effusion. Assessment/Plan: Claimant has some synovitis in the knee as well as aggravated arthritis. Performed cortisone injection in knee today. Return for evaluation in two weeks, continue off work until then.

03-14-13: Office Visit. Claimant presented with continued pain and minimal improvement after injection. PE: Right knee: Noted medial joint line pain but no lateral joint line pain. He has mild patellofemoral crepitus and tenderness with manipulation of the undersurface of the patella. Assessment/Plan: The claimant has mild to moderate arthritis in the knee involving grade II chondromalacia of the patellofemoral area, as well as the medial and lateral tibial plateau. Ordered MRI with contrast to rule out a repeat tear versus possible worsening of his arthritic condition.

03-28-13: MRI Knee Right W Contrast. Impression: 1. Interval subtotal right knee medial meniscectomy with resection of a large portion of the posterior horn and posterior root right knee medial meniscus. No contrast imbibitions into the remaining right knee medial meniscus to suggest residual or recurrent right knee

medial meniscus tear. 2. Unchanged mild medial and patellofemoral compartment right knee chondrosis. 3. Healing subchondral insufficiency fracture, right knee medial femoral condyle with extensive medial femoral condyle marrow edema. 4. Unchanged mild distal quadriceps tendinopathy without tear.

04-01-13: Office Visit. Claimant presented with continued pain to right knee. PE: Right knee: Noted swelling of the knee with some mild medial joint line pain, especially over the medial femoral condyle. Assessment/Plan: There is no evidence of a re-tear of his medial meniscus. He does have some edema in the medial femoral condyle and will perform Depo-Medrol injection today to right knee. Recommend holding off on additional physical therapy. Return for re-evaluation in one month and recommend he continue off work until then.

05-06-13: Office Visit. Claimant presented with continued right knee pain and noted temporary improvement before pain returned. He stated he is having multiple issues with popping and instability of knee. Claimant reported falling three times since last visit. PE: Direct examination of the right knee showed continued pain over the medial femoral condyle and medial meniscus, joint line pain, positive McMurray's. Assessment/Plan: Claimant continued with pain and instability; will place in hinged brace today. He is a good candidate for diagnostic arthroscopy of his knee. It is believed that the continued pain and instability is a result of some residual tear or new tear that was not seen on MRI.

05-14-13: UR performed. Reason for denial: The clinical information provided does not establish the medical necessity of this request. According to the ODG Guidelines regarding diagnostic arthroscopy for the knee, "Recommended as indicated below. Second look arthroscopy is only recommended in case of complications from OATS or ACI procedures, to assess how the repair is healing, or in individual cases that are ethically defensible for scientific reasons, only after a thorough and full informed consent procedure. In patients with osteoarthritis, the value of MRI for a precise grading of the cartilage is limited, compared to diagnostic arthroplasty. When the assessment of the cartilage is crucial for a definitive decision regarding therapeutic options in patients with osteoarthritis, arthroscopy should not be generally replaced by MRI. The diagnostic values of MRI grading, using arthroscopy as reference standard, were calculated for each grade of cartilage damage. For grade 1, 2 and 3 lesions, sensitivities were relatively poor, whereas relatively better values were noted for grade 4 disorders. Criteria include: (1) Conservative care: Medications or physical therapy. Plus subjective clinical findings of pain and functional limitations continue despite conservative care. Plus imaging clinical findings: Imaging is inconclusive." Also according to ODG Guidelines regarding meniscectomy, indications for Surgery – Meniscectomy: "Criteria for meniscectomy or meniscus repair (Suggest 2 symptoms and 2 signs to avoid scope 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. Conservative care: (Not required for locked/blocked knee) with physical therapy or medication

or activity modification. Plus, subjective clinical findings of at least 2, including joint pain or swelling or feeling of give way or locking, clicking, or popping. Plus, objective clinical findings of at least 2 including positive McMurray's sign or joint line tenderness or effusion or limited range of motion or locking, clicking, or popping, or crepitus. Plus, imaging clinical findings (Not required for locked/blocked knee) of Meniscal tear on MRI." In this case, a new Meniscal tear was not demonstrated on the MR arthrogram. The patient has always had reasons for continued pain including osteoarthritis on c-rays, and prior surgery showing decreased joint space. Also, there were concerns about the change in the medial femoral condyle which was called subchondral insufficiency fractures which also could be signs of avascular necrosis. Both arthritis and change in the medial femoral condyle could be the source of pain, both of which would not respond to arthroscopic treatment. Therefore, based on evidence-based guidelines and medical evidence provided, this request has been determined to not be supported for medical necessity.

05-16-13: Letter of Appeal. The claimant is a status post arthroscopy of his right knee with continued pain. He had a partial meniscectomy and chondroplasty and has continued issues with his knee, not only popping, but instability of the knee. There is no evidence on the MRI of a re-tear and showed arthritis as well as several loose fragments present in the knee as well as a contusion to the medial femoral condyle with no evidence of re-tear. He had a subchondral insufficiency fracture of the femoral condyle as well. The claimant has already failed conservative management including anti-inflammatories and repeat injection therapy. Discussed with the claimant the procedure to perform a diagnostic and therapeutic arthroscopy of the right knee, to not only reevaluate the meniscus, but also to evaluate the arthritis with possible loose chondral pieces. He is unable to return to work and is unable to continue conservative management and wants to return to work.

05-22-13: UR performed. Reason for denial: The clinical evidence does not establish medical necessity for this request. According to the ODG Guidelines, indications for meniscectomy: "Conservative care: Exercise: physical therapy and medications or activity modification. Plus: Subjective clinical findings of at least two: Joint pain or swelling or feeling of give way or locking, clicking or popping. Plus: Objective clinical findings: positive McMurray's sign or joint line tenderness or effusion or limited range of motion or locking, clicking, or popping, or crepitus. Plus, imaging clinical findings of Meniscal tear on MRI." At this time, there is no indications that the patient has a meniscal tear on MRI; therefore, the request is not established for medical necessity. Regarding the request for diagnostic arthroscopy, according to the ODG Guidelines, indications for diagnostic arthroscopy: Conservative care: Medications or physical therapy. Plus Subjective clinical findings: Pain and functional limitations continue despite conservative care. Plus: Imaging clinical findings: Imaging is inconclusive. At this point, the patient continues to have pain and has undergone injections and has some degenerative changes in the knee; however medical necessity has not been established for this request.

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

The previous adverse determinations are partially overturned. The request for arthroscopic surgery of the right knee in this case is recommended. The claimant has exhausted conservative care and physical therapy and continues to have pain with MRI findings that are inconclusive in my opinion. Per ODG Guidelines Knee & Leg, recommendations for diagnostic arthroscopy are pain, popping, locking, giving way and positive McMurray's on exam; which is noted 5/6/13 office visit and reiterated in the letter of appeal on 5/16/13. There however are no indications for synovial biopsy in this case. MRI frequently is not reliable in post op meniscectomy cases for re-tears or loose bodies. Therefore, after review of the medical records and documentation provided, the request for Arthroscopy, Knee Diagnostic, with or without Synovial Biopsy (Separate Procedure) is medically necessary without Synovial Biopsy and therefore partially overturned.

Per ODG:

<p>Diagnostic arthroscopy</p>	<p>Recommended as indicated below. Second look arthroscopy is only recommended in case of complications from OATS or ACI procedures, to assess how the repair is healing, or in individual cases that are ethically defensible for scientific reasons, only after a thorough and full informed consent procedure. (Vanlauwe, 2007) In patients with osteoarthritis, the value of MRI for a precise grading of the cartilage is limited, compared to diagnostic arthroplasty. When the assessment of the cartilage is crucial for a definitive decision regarding therapeutic options in patients with osteoarthritis, arthroscopy should not be generally replaced by MRI. The diagnostic values of MRI grading, using arthroscopy as reference standard, were calculated for each grade of cartilage damage. For grade 1, 2 and 3 lesions, sensitivities were relatively poor, whereas relatively better values were noted for grade 4 disorders. (von Engelhardt, 2010)</p> <p>ODG Indications for Surgery™ -- Diagnostic arthroscopy: Criteria for diagnostic arthroscopy: 1. Conservative Care: Medications. OR Physical therapy. PLUS 2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS 3. Imaging Clinical Findings: Imaging is inconclusive. (Washington, 2003) (Lee, 2004) 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)**