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Notice of Independent Review Decision

September 13, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left knee arthroscopy with meniscectomy.

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

Certified by the American Board of Orthopaedic Surgery
Recertified by the American Board of Orthopaedic Surgery, 2011
Orthopaedic Sports Medicine Subspecialty CAQ, ABOS, 2011

REVIEW OUTCOME:

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

X 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:

- Utilization reviews (08/06/13, 08/27/13)

- Diagnostic (09/11/12)
- Procedure (10/09/12)
- Therapy (11/19/12 – 11/29/12)
- Office visits (07/19/13 - 08/01/13)
- Utilization reviews (08/06/13, 08/27/13)

- Office visits (08/14/12 – 08/01/13)
- Diagnostics (09/11/12 – 09/18/12)
- Procedure (10/09/12)

- Utilization reviews (08/06/13, 08/27/13)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, slipped on some stairs, and landed on his back, alleging injuries to his back and knee.

On August 14, 2012, evaluated the patient for lower back and knee injury. The mechanism of injury was forward bending, landing on the lumbar and the lumbosacral region. The patient stated he had numbness in his left leg. He reported that he initially had left knee pain that had resolved but he continued to have back pain. Examination of the lumbar spine showed tenderness of the paraspinal muscles at L3, L4 and L5. X-rays of the lumbar spine were unremarkable. Diagnoses were low back strain, back pain, back strain, lumbar radiculopathy and lumbar strain. The patient was prescribed ibuprofen and was recommended physical therapy (PT). However, the patient refused therapy and wanted to see a specialist.

On September 6, 2012, evaluated the patient for injuries sustained while working. noted the patient was injured as a result of falling. The patient reported low back pain with radiating pain to the left leg and pain and catching in the left knee. Examination of the left knee showed medial joint line tenderness, 1+ effusion and positive McMurray's test. Examination of the low back showed a weakly positive straight leg raise (SLR) on the left. stated that the patient was symptomatic now for six weeks. He recommended magnetic resonance imaging (MRI) of the left knee and low back. The patient was to work regular duty.

On September 11, 2012, MRI of the left knee identified: (1) Extensive abnormal signal with a moderate-sized oblique tear involving the posterior horn of the medial meniscus with blunting of the free edge. The cartilage appeared maintained in the medial compartment. (2) There appeared to be a radial tear involving the lateral meniscus. The cartilage appeared maintained in the lateral compartment. (3) Moderate edema and irregularity involving the distal attachment site of the patellar tendon. There was some fraying of the undersurface or deep fibers possibly representing a partial-thickness tear of the distal fibers 30 percent in severity. No full-thickness tear or retraction was evident. (4) Evidence for mild tendinosis/tendinitis distal quadriceps tendon. The tendon itself appeared intact.

On September 11, 2012, MRI of the lumbar spine identified: (1) Evidence for a posterior annular tear with a high intensity zone at the L5-S1 level. It could result in discogenic pain suggestive of an acute finding. There was an associated 3-mm slightly right-sided disc protrusion/herniation at this site. Moderate to moderately severe compromise of the right lateral recess, contact and some compression of the right S1 nerve root sheath. It could result in right-sided S1 symptoms. Spinal canal did remain slightly in excess of a centimeter. There was mild compromise of the left lateral recess and mild neural foraminal encroachment bilaterally. (2) There was mild spinal canal stenosis at L4-L5. Spinal canal was 9 mm in AP

dimension. This was due to a 2 to 3 mm disc bulge. There was mild-to-moderate compromise of the left and right lateral recesses. It could potentially result in bilateral L5 symptoms.

On September 13, 2012, reviewed the lumbar spine and left knee MRIs. It was noted that the lumbar spine MRI was positive for high-intensity zone at L5-S1. He had central canal herniation. MRI of the left knee showed medial and lateral meniscus tears. The patient had been advised that he needed arthroscopy of left knee for his medial and lateral meniscus tears. For back, recommended either taking an anti-inflammatory or possible epidural steroid injection (ESI). The patient wanted to try medications initially. He now reported that his right knee had been bothering him and he wanted to check that. He had significant medial joint line pain and a positive jump test. recommended an MRI of the right knee and a right knee arthroscopy.

On September 18, 2012, MRI of the right knee identified: (1) There was a small to moderate-sized oblique tear involving the posterior horn of the medial meniscus. The tear extended to the inferior articular margin. The cartilage was maintained. (2) There was mild cartilage loss in the patellofemoral compartment. The patella appeared tilted slightly in the lateral direction. There was also moderate thickening and bony overgrowth involving the distal patellar tendon. The tendon itself appeared intact.

On September 21, 2012, noted that the MRI was positive for medial meniscus tear of the right knee. The patient was known to have medial and lateral meniscus tears of the left knee. The patient was advised that he needed arthroscopy of left knee first and then eventually the right knee.

On October 9, 2012, performed operative arthroscopy of the left knee with partial lateral meniscectomy and medial meniscus repair (meniscal recess posterior horn) with Fast-Fix devices.

On October 19, 2012, recommended strict nonweightbearing protocol and off work.

On follow-ups in November, noted that the patient was ready to start 50% weightbearing with crutches. He recommended doing this for two weeks.

From November 19, 2012, through November 29, 2012, the patient attended eight sessions of PT consisting of hot/cold packs, therapeutic exercises and manual therapy.

2013: On January 3, 2013, noted that the patient had been in PT for four weeks. He was doing very well. He had full range of motion (ROM). His puncture sites looked good. He has minimal swelling. He still complained of aches and pain. Most of his pain seemed to be in the patella tendon area. thought that the patient had a little tendonitis. He further stated that the right foot was not related to Workman's Compensation. The patient's right foot was huge and his right great

toe definitely looked like he had gout and he did have a history of gout. gave Indocin SR for the patellar tendonitis on the left knee, which would help with the gout on his right foot, if it was gout. The patient was nonweightbearing and walking with crutches for a long period. recommended light duty work with no kneeling or squatting and follow-up in four weeks.

On January 31, 2013, released the patient on full duty work through February 1, 2013.

On February 21, 2013, the patient reported that his left knee still hurt despite the surgery. He wanted to have a repeat MRI. Clinical exam showed mild medial joint line tenderness. Diagnosis was residuals of knee scope. recommended MRI.

On July 19, 2013, evaluated the patient for pain in the lumbar region and bilateral knees. The patient reported that he went for designated doctor evaluation (DDE) on July 8, 2013. He reported pain level of 6-7/10 with numbness and tingling in left leg to left foot. He had right knee pain rated as 6/10 with occasional popping. He had left knee pain rated as 6/10 with painful popping. The pain would increase with prolonged standing. His gait was antalgic and compensated. He had mild effusion in the left knee and a surgical scar on the anterior knee. Examination of the left knee showed mild tilt, crepitus, positive apprehension, 2+ popliteal pulse, flexion 120 degrees, extension 3 degrees, trace of valgus stress and positive McMurray's medial and Apley's grind as well as FABERE's tests. Examination of the right knee showed mild tilt, positive apprehension, 2+ popliteal pulse, flexion 140 degrees, extension 3 degrees and positive Apley's grind. Examination of the lumbar spine showed mild muscle spam and sacroiliac (SI) joint tenderness with pain bilaterally. The patient had positive Fabere's test and Gaenslen's on the left. Open book stress resulted in increased hip pain whereas closed book stress reproduced back pain. Right hip internal rotation resulted in hip and knee pain. Diagnosis was bilateral sprain of SI joint, bilateral tear of the medial meniscus of the knee, tear of lateral meniscus, bilateral patellar tilt and lumbar disc displacement. stated that the patient had not responded to PT and medications for the back pain. He recommended SI joint injections and post injection PT, a lumbar MRI prior to the injections and continuing medications. He further stated that the patient had a horizontal medial meniscal tear and the pain was coming from the posteromedial aspect of the knee. He believed that the medial meniscal repair was not successful and one should proceed with a revision meniscal debridement. He did not feel that a postoperative MRI would be helpful as obtaining an MRI would be waste of time and money. He requested surgery regardless of the outcome. He recommended learning more about the postoperative pain with the diagnostic portion of the arthroscopy and also obtaining an AP pelvis to evaluate the hip.

Per report dated August 1, 2013, it was noted the patient was to undergo a left knee arthroscopy with meniscectomy on an outpatient basis.

Per utilization review dated August 6, 2013, the request for outpatient surgery, left knee arthroscopy with meniscectomy was denied with the following rationale: *"This patient had prior left knee arthroscopy on October 8, 2012. There was a DDE on July 8, 2013. on his July 19, 2013, report stated the symptoms were on the right side (knee) but then also reports pain in the left knee. The July 19, 2013, office note has essentially no knee exam. stated that there was no postoperative MRI but that such a test is wasteful, as surgery is needed regardless. The operative report of October 9, 2012, was forwarded. did attest a posterior horn medial meniscus repair with three FasT Fix devices. There were no recent operative surgeon records or the DDE or confirmatory imaging study. Further validation possibly a post Designated Doctor RME would be prudent before further surgery is completed."*

Per reconsideration review dated August 27, 2013, the request for outpatient surgery, left knee arthroscopy with meniscectomy was denied, with the following rationale: *"Based on the clinical documentation submitted for review and current evidence-based guidelines the proposed revision left knee arthroscopy for meniscectomy would not be supported as medically necessary. No post-operative imaging studies of the left knee were submitted for review identifying further pathology at the medial meniscus that would reasonably require revision procedure. Per current evidence-based guidelines patients are recommended to have MRI clearly identifying pathology that correlates with objective findings. Given the absence of any updated imaging for the left knee, the request would not meet guideline recommendations and medical necessity is not established."*

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

The request is for a left knee arthroscopy with meniscectomy.

The ODG indications are cited as:

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).

While I concur that the left knee symptoms are likely due to a failure of the attempted medial meniscus repair, there is insufficient evidence-based rationale presented to obviate the standard ODG criteria, which serve as the TDI-sanctioned baseline for determining the appropriateness of the request for partial

meniscectomy. Part of the criteria includes a MRI study demonstrating concordant pathology. A postoperative MRI is considered reasonable by ODG (see below) as a preoperative study to confirm a persistent medial meniscus tear following attempted repair:

Indications for imaging -- MRI (magnetic resonance imaging):

- Acute trauma to the knee, including significant trauma (e.g., motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption.
 - Nontraumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed.
 - Nontraumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary, and if internal derangement is suspected.
 - Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected.
 - Nontraumatic knee pain, adult - nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Peligrini Stieda disease, joint compartment widening).
- Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Ramappa, 2007)** Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. ([Weissman, 2011](#))

A MR-arthrogram would be the preferred type of MRI study in the postoperative setting.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

Jeffrey J. Nepple, Warren R. Dunn, Rick W. Wright; Meniscal Repair Outcomes at Greater Than Five Years: A Systematic Literature Review and Meta-Analysis. The Journal of Bone & Joint Surgery. 2012 Dec;94(24):2222-2227.