

Health Decisions, Inc.

4517 Coconino Court
Fort Worth, TX 76137
P 972-800-0641
F 888-349-9735

Notice of Independent Review Decision

November 10, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient left knee arthroscopy, medial meniscus repair with prosthesis, joint exploration and biopsy with removal of loose bodies/foreign bodies

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

An American Board Certified Orthopedic Surgeon with over 13 years of experience

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male that tripped on the job on xx/xx/xx lower left leg pain.

04-24-14: Operative Report. Pre-op Dx: Mechanical sx and locking left knee after a Worker's Compensation injury. Suspect meniscal or chondral pathology, left knee. Torn left ankle anterior talofibular ligament with recurrent instability and a positive anterior drawer. Ongoing recalcitrant plantar fasciitis with pain and tenderness over the medial cord of the left plantar fascia. Improving paratenon inflammation of the left Achilles, which has improved quite a bit in the interim. Post-op Dx: Large loose body, left knee, causing locking and mechanical sx. Osteochondral dime-size injury to the medial femoral condyle, which was full-thickness injury down to the bone. Osteochondral injury in the midline of the trochlea, which was 1 cm x 4 cm in length. Osteochondral injury on a small

portion of the patella. Torn anterior talofibular ligament with only partial tearing of the calcaneofibular ligament, left ankle. Chronic plantar fasciitis with thickening of the medial cord. Potentially entrapped nerve to the abductor digiti quinti near the chronic plantar fasciitis. Procedures Performed: Arthroscopy of the left knee with removal of mechanical loose body. Microfracture of osteochondral injuries to the medial femoral condyle and to the trochlear and to the patella. With separate incisions, left ankle Brostrom ligament reconstruction for torn anterior talofibular tear and partial tearing of the calcaneofibular tear. Deep rerouting and advancement of extensor retinaculum, left ankle. Partial plantar fascia release. Decompression of the nerve to the abductor digiti quinti.

05-05-14: Office Visit Report. The claimant presents with left knee pain rated 5-6/10. Here for suture removal. He is still wearing boot and using crutches. ROS reveals joint pain, knee and lower leg has incisions that are clean and dry, mild swelling, good SLR, ROM 0-120. Ankle and foot incisions are clean and dry, mild swelling and erythema and bruising, no signs/sx of infection, stable anterior drawer, motor and sensation intact. Current Problems: Left knee/ankle/foot pain. Plan: Continue low impact activities, left ankle brace; CAD/CAM; and assistive devices crutches. Elevate extremity when at rest. Continue home exercise and ice tx. Initiate PT.

05-14-14: Physical Therapy Evaluation/Reevaluation by PT. The claimant present with really sore left knee rates 5/10. He c/o burning and aching on both sides of left knee and swelling depends on activity. On evaluation, AROM Knee: Extension L +2, R 0. Flexion L 108 degrees, R 140 degrees. Girth: Knee joint L 39.0, R 37.0. Quad L 50.4, R 51.2. Gait: Bilat crutches and walking boot on left. Balance: EO L unable – in boot for ankle surgery, R good. EC L NT, R NT. Recommend: Skilled PT to restore function 2 x per week x 4 weeks, then Q week x 12 weeks.

05-21-14: Left Knee MRI. Impression: 1. Small joint effusion. 2. No bone contusions. 3. Normal cruciate ligaments and collateral ligaments and normal menisci. 4. Moderate patellofemoral arthritis. Well maintained medial and lateral compartment weight-bearing cartilage.

08-12-14: Office Visit Report. The claimant c/o left knee popping and buckling d/t re-injury on xx/xx/xx rates pain 6-8/10. He states left ankle stiffness with 3-4/10 pain. Upon exam, left knee and lower leg: TTP over MJL and LJL, TTP over medial femoral condyle, 10-90 degrees ROM, 1+ effusion, good SLR with no extensor lag, stable ligamentous exam. Plan: Continue Norco and start OTC NSAIDS start low impact straight ahead activities.

09-02-14: MRI of Left Knee. Impression: 1. Myxoid degeneration in the posterior horn of the medial meniscus. 2. Advanced chondromalacia of the femoral trochlea with multiple areas of full thickness cartilage loss and subchondral edema formation. 3. Moderate chondromalacia of the lateral patellar facet.

09-05-14: Office Visit Report. The claimant c/o left knee pain. On exam, left knee and lower leg without changes than previous exam. Current Problems: Left knee pain, left knee sprain/strain, medial meniscus tear. Plan: Continue low impact activities, continue current medications, recommend MRI and using hinged knee brace, given today.

09-10-14: Office Visit Report. The claimant present with left knee pain rated 4-7/10. He is not approved for additional PT. Upon exam, left knee and lower leg has patellofemoral crepitus and anteromedial knee pain.

09-23-14: URA. Rationale: There must be documentation of lower levels of care with findings of swelling and give-way, locking, clicking, popping, positive McMurray's, joint line tenderness, effusion, limited range of motion and imaging showing meniscal tear. The MRI from 09-02-14 was reported to show myxoid degeneration of the posterior horn of the medial meniscus, however, there was no documentation of a tear. There were no notes to indicate the current lower levels of care the claimant has undergone. The records do not reflect when the claimant underwent physical therapy, how much, and what the outcome was. The records do not reflect the previous meniscectomy or meniscal repair. The request for a left knee arthroscopy, medial meniscus repair with prosthesis, joint exploration, and biopsy or removal of loose body or foreign bodies is not certified.

10-16-14: URA. Rationale: This is a non-certification of an appeal of a left knee arthroscopy, medial meniscus repair with prosthesis, joint exploration and biopsy with removal of loose bodies/foreign bodies. The previous non-certification on 09-17-14 was due to lack of documentation of lower levels of care, sufficient physical examination findings, or sufficient imaging findings. The previous non-certification is supported. Additional records were not provided for review. There was no documentation of any home exercise program or cortisone injection to the knee. The physical examination documented no positive McMurray's sign or effusion. The MRI reported no meniscal tear as required by the guidelines. I discussed the case with who stated that he has been authorized to do the peer to peer call. They want to do arthroscopy and patella femoral prosthetic replacement for advanced patella femoral degeneration. The claimant has failed, physical therapy, and steroid injections and has a micro fracture. I advised him to resubmit without a medial Meniscectomy. The request for an appeal of a left knee arthroscopy, medial meniscus repair with prosthesis, joint exploration and biopsy with removal of loose bodies/foreign bodies is not certified.

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

The patient is not indicated for outpatient left knee arthroscopy, medial meniscus repair with prosthesis, joint exploration and biopsy with removal of loose bodies/foreign bodies. There is inadequate documentation of conservative care prior to surgical consideration. It is unclear how the patient has responded to medication, physical therapy, or cortisone injection. The record does not document mechanical complaints or physical findings consistent with meniscal

pathology. Furthermore, the 9/2/2014 MRI study demonstrates myxoid degeneration of the medial meniscus. There is no meniscal tear that requires surgical intervention. In addition, there is no mention of loose bodies or foreign bodies in this MRI report. The requested outpatient left knee arthroscopy, medial meniscus repair with prosthesis, joint exploration and biopsy with removal of loose bodies/foreign bodies is not medically necessary.

Per ODG:

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).

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)