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Notice of Independent Review Decision

November 18, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right knee arthroscopy with meniscectomy and chondroplasty

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.

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who hit his right knee on xx/xx/xx.

On June 30, 2014, NP, evaluated the patient for **right** knee complaints. The patient reported his x-rays were negative and magnetic resonance imaging (MRI) was ordered. His knee would swell at work, go out of place, and pop. The patient was involved in a motor vehicle accident (MVA) and broke his left femur that had three screws in place. The patient reported immediate onset of pain located on the lateral aspect of the right knee rated as 8/10. Flexion, extension, standing, lifting, twisting, walking, bending knee or squatting exacerbated the symptoms. Associated symptoms included popping, swelling, giving way and locking. Examination of the right knee revealed moderate distress secondary to pain,

moderate swelling warmth on the right popliteal area, favoring the right leg, decreased flexion and extension, crepitus during range of motion (ROM) testing, pain and difficulty with squatting, tenderness of the popliteal area and laterally on the right. Ms. diagnosed knee pain and sprain/strain of the knee/leg. She prescribed Medrol Dosepak and ibuprofen, recommended structured physical therapy (PT) program, provided a knee brace and ordered MRI and computerized tomography (CT) arthrogram.

On July 3, 2014, an MRI of the right knee revealed a complex tear of the medial meniscus posterior horn and body, flap-type tear of the medial meniscus body with displacement of the meniscal flap anteriorly and superiorly along the anterior horn-body junction. There was a horizontal component of the tear through the posterior horn. There was moderate (medial compartment predominant) tricompartmental right knee chondrosis with subchondral edema in the medial compartment. There was a moderate right knee effusion with a moderate-sized Baker's cyst. There was mild superficial infrapatellar bursitis, and intact right knee lateral meniscus and ligaments.

On July 11, 2014, reviewed the MRI findings and diagnosed knee contusion, meniscus tear and knee pain. She prescribed Norco and provided a cane. The patient was referred to an orthopedic surgeon.

On July 30, 2014, evaluated the patient for right knee complaints. noted the patient sustained traumatic injury to the right knee when he hit the knee hard. He reported the injury but was able to continue driving. He told them that he hurt it pretty bad, but since that time he had chronic swelling and popping and pain in the knee, occasionally giving way. The knee popped, clicked and would give way. It had gotten to the point where he could not kneel down on it. The patient was unable to continue to drive. He was off work. History was positive for traumatic injury, broken left femur in xxxx in a motorcycle wreck (was told he might lose his leg) and history of cervical fusion in 1995. Examination revealed an antalgic gait on the right, inability to toe or heel walk or squat without discomfort. Examination of the right knee revealed limited flexion; past 90 he had marked discomfort. There was markedly positive McMurray's on the medial joint line. Standing films of the right knee showed excellent alignment without any significant degenerative changes. diagnosed right knee torn medial meniscus and chondrosis of the medial femoral condyle. He recommended arthroscopy and administered Celestone/Xylocaine, Depo Medrol, Xylocaine and lidocaine injection to the knee.

On August 13, 2014, noted no improvement after the injection. Examination revealed a markedly antalgic gait on the right, inability to toe or heel-walk or squat without discomfort. There was some patellofemoral apprehension and markedly positive McMurray on the medial joint line. recommended arthroscopy.

Per a utilization review dated September 4, 2014, the request for right knee arthroscopy with meniscectomy and chondroplasty was denied with the following rationale: "*The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The mechanism of injury is the*

patient hit his knee. Medication was not provided. Surgical history included a cervical fusion in 1995. Diagnostic studies included an official MRI of the right knee dated July 3, 2014, which revealed a complex tear of the medial meniscus posterior horn and body. There is a flap-type tear with the medial meniscus body with displacement of the meniscus flap anteriorly and superiorly along the anterior horn-body junction. There is a horizontal component of the tear through the posterior horn. Moderate medial compartment predominant, tricompartmental right knee chondrosis with subchondral edema in the medial compartment, moderate right knee effusion with moderate size Baker cyst, mild superficial infrapatellar bursitis, intact right knee lateral meniscus and ligaments. Other therapies were not provided. The patient is a male who reported an injury on xx/xx/xx. The initial evaluation dated July 30, 2014, indicated that the physician administered the patient's right knee with Celestone/Xylocaine solution, 3 mL of Depo-Medrol, 2 mL of Xylocaine and 2 mL of lidocaine. The office note dated August 13, 2014, indicated the patient reported that he had not improved with the injection he was given on the previous visit. The patient reported chronic pain to the right knee with chronic swelling and popping and occasionally giving way. The patient reported that the knee had pain medially. The patient reported it had gotten to where he was unable to kneel down on his knee, and that he was unable to play with his grandchildren without severe discomfort. The patient reported he had been unable to drive. Upon examination, the patient was noted to ambulate with an antalgic gait on the right. The patient was unable to toe or heel walk or squat without discomfort. The patient was able to have good range of motion in his hips, left knee, and ankle. The right knee range of motion was limited in flexion past 90 degrees, with marked discomfort. There was no significant instability pattern noted. The physician indicated the patient did have some patellofemoral apprehension. The McMurray's was positive on the medial joint line. The physician indicated the patient had significant bone marrow edema of the medial femoral condyle, which was related to the torn medial meniscus, and recommended the patient undergo arthroscopy for a torn medial meniscus and chondrosis, medial femoral condyle. The Official Disability Guidelines state that the criteria for meniscectomy or meniscus repair is conservative care to include exercise or physical therapy and medication or activity modification plus subjective complaints of joint pain, swelling, feeling of giving way, or locking, clicking, or popping, plus objective findings of a positive McMurray's sign, joint line tenderness, effusion, limited range of motion, locking, clicking, popping, or crepitus, plus a meniscal tear on MRI. Furthermore, the Official Disability Guidelines state that the criteria for chondroplasty is conservative care to include medication or physical therapy plus subjective complaints of joint pain and swelling plus objective findings of effusion, crepitus, or limited range of motion plus a chondral defect on MRI. The records submitted for review indicated that the MRI of the right knee revealed a complex tear of the medial meniscus posterior horn and body, moderate medial compartment predominant, tricompartmental right knee chondrosis with subchondral edema in the medial compartment. In addition, the records submitted for review indicated that the patient had complaints of right knee pain, swelling, popping, clicking, and giving way. Upon examination, the patient was noted to have an antalgic gait and was unable to toe or heel walk or squat without discomfort. There was limited range of

motion of the right knee past 90 degrees with discomfort. There was a positive McMurray's on the medial joint line. However, the records submitted for review failed to include documentation of conservative care to include exercise/physical therapy. Given the above, the request for OP Right Knee Arthroscopy with Meniscectomy & Chondroplasty 29881, 29879 is non-certified."

On September 25, 2014, Ms. noted the right knee surgery was denied because the patient never had PT. Examination revealed an antalgic gait, tenderness on the medial aspect of the right knee, right knee swelling, limited ROM and diffuse stiffness. She diagnosed knee pain and meniscus tear, prescribed a point relief tube with applicator, Colace and hydrocodone-acetaminophen and recommended PT.

Per a reconsideration review dated October 9, 2014, the appeal for right knee arthroscopy with meniscectomy and chondroplasty was denied with the following rationale: *"The patient is a male who injured his right knee on xx/xx/xx, when he hit his knee. The patient is diagnosed with right internal knee derangement. An appeal for right knee arthroscopy with meniscectomy and chondroplasty has been made. The request was previously denied since the records submitted for review failed to include documentation of conservative care to include exercise/physical therapy. There is an updated documentation submitted for review including a recent medical record dated September 25, 2014. MRI of the right knee dated July 3, 2014 revealed a complex tear of the medial meniscus posterior horn and body. There is a flap type tear with the medial meniscus body with displacement of the meniscus flap anteriorly and superiorly along the anterior horn-body junction. There is a horizontal component of the tear through the posterior horn. Moderate medial compartment predominant, tricompartmental right knee chondrosis with subchondral edema in the medial compartment, moderate right knee effusion with moderate size Baker cyst, mild superficial infrapatellar bursitis, and intact right knee lateral meniscus and ligaments. The patient was initially treated with medications and a corticosteroid injection on July 30, 2014, which did not provide any relief. On August 13, 2014 follow-up, he complained of chronic right knee pain with swelling, popping and occasional giving way. Physical examination on that visit showed an antalgic gain on the right. He was unable to toe or heel walk or squat without discomfort. There was good range of motion in his hips, left knee, and ankle. The right knee range of motion was limited in flexion past 90 degrees with marked discomfort. There was no significant instability pattern noted. There was some patellofemoral apprehension. McMurray's test was positive on the medial joint line. X-rays of the right knee were unremarkable. The recent medical record dated September 25, 2014 indicates that the patient complains of right knee pain. Current medications include hydrocodone-acetaminophen and Colace. Physical examination revealed tenderness and swelling with limited range of motion. While a surgical intervention is considered, there was no evidence in the medical reports submitted that the patient has exhausted conservative treatment including physical therapy and weight loss program prior to the proposed surgery. As per guidelines, arthroscopic lavage and debridement in patients with osteoarthritis of the knee is no better than placebo surgery and provides no additional benefit compared to*

optimized physical and medical therapy. In agreement with the previous determination, the medical necessity of the request has not been substantiated.”

On October 29, 2014, Ms. noted the patient had ongoing knee pain and knee giving out without the brace. Examination revealed a normal gait, right knee swelling, tenderness, diffuse stiffness and limited ROM. She prescribed tramadol and referred the patient to an orthopedic specialist.

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

Aside from no documentation of PT, the claimant substantially meets the criteria for partial meniscectomy. PT was ordered. PT is not anticipated to produce a cure at this point in the treatment course.

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).

The claimant does not meet the criteria for chondroplasty (there is no MRI evidence of an acute, focal traumatic chondral defect).

ODG Indications for Surgery -- Chondroplasty:

Criteria for chondroplasty (shaving or debridement of an articular surface), requiring ALL of the following:

1. Conservative Care: Medication OR Physical therapy. PLUS

2. Subjective Clinical Findings: Joint pain. AND Swelling. PLUS

3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS

4. Imaging Clinical Findings: Chondral defect on MRI ([Washington, 2003](#)) ([Hunt, 2002](#)) ([Janecki, 1998](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).

Arthroscopic partial medial meniscectomy (without chondroplasty) is the appropriate intervention in this case. The request for chondroplasty results in appropriate nonauthorization.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES