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Notice of Independent Review Decision

**July 14, 2014**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Left knee surgery – medial meniscal tear

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

Orthopedic Physician

**REVIEW OUTCOME:**

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

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 (05/21/14, 06/11/14)
- Office visits (04/14/14 – 05/15/14)
- Utilization reviews (05/21/14, 06/11/14)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is male who was injured on xx/xx/xx, injuring his left knee and left ankle.

On April 14, 2014, evaluated the patient for pain in the left knee medial side and pain in the left ankle. The patient's left knee and ankle had swollen. He had pain in the ankle with walking and in the knees also. The ankle was stiff as was the knee. On examination, the right forearm showed a slight abrasion with slight

tenderness at the abrasion. The left knee showed swelling and mild tenderness in the medial femoral epicondyle. Left lower leg showed mild swelling with tender distal gastrocnemius and into the Achilles. The left ankle was diffusely swollen with tender medial malleolus. There was pain on the ankle with motion. The left ankle was mildly limited more on inversion and eversion. There was ecchymosis along the base of the middle ankle. There was mild pain on compression of the ankle from the sites. Left foot was swollen around the ankle and extending into the foot. X-rays of the knee showed degenerative arthritis involving the left knee and osteophytes. X-rays of the tibia/fibula were unremarkable. X-rays of the left ankle showed moderate degenerative arthritis. diagnosed sprain/strain of the knee/leg unspecified site, sprain/strain of the ankle, unspecified site, knee contusion, and knee abrasion, lower leg contusion, abrasion of the lower leg, forearm contusion and forearm abrasion. provided injection TDAP and prescribed over-the-counter ibuprofen. Biofreeze was dispensed. placed the patient on modified activity to include sitting 85% of the time, no climbing, no squatting, no kneeling and mostly sitting job and elevation of the left leg as much as possible.

On April 17, 2014, evaluated the patient for ongoing symptoms. The patient stated that the medial side of the knee was still very sore and seemed to be getting more range of motion (ROM) with flexion and extension. The left knee was still swollen and he had increased ecchymosis on the medial side of the ankle. He had continued to work. encouraged staying off his foot, icing and elevating his ankle. dispensed ibuprofen and recommended a fracture walker.

On April 21, 2014, the patient felt that he pattern of symptoms was stable. His left knee was still sore medially and he would get stiff when he sat for a long time. The medial aspect of the left ankle was still hurting and he had been trying to keep it elevated when he could. He was wearing the boot and was rubbing at the spot where he had abrasion and had some swelling there. He stated that it was better when he propped it up, but got out after he had elevated. He could feel blood rush down into it and had to pause a bit. On examination, he had abrasion posteromedially on the left lower leg above the ankle. He had a knot beside the abrasion. The left knee showed full ROM, but was tender medially. The left ankle showed moderate swelling of the medial side, but was decreased from previously. Motion was good on dorsi and plantarflexion, but limited to inversion and eversion. There was tenderness on the medial ankle/medial malleolus. recommended continuing to elevate the foot as much as possible and use cushion around the abraded area to keep the boot from rubbing there. recommended physical therapy (PT) three times a week for one to two weeks. The patient was recommended continuing modified activity.

On April 28, 2014, the patient noted worsening of his symptoms. The ankle was getting better, but the left knee was hurting a lot and at the end of the day he was not able to bend it as it would get very stiff and painful. He felt that it locked up. The pain was in the medial part of the knee and the medial joint line (MJL) area. The patient had PT and continued working within the duty restrictions. On examination, the left knee showed ROM was mildly limited on flexion with pain. There was tender MJL, minimal swelling noted, some mild anterior cruciate

ligament (ACL) laxity, but otherwise stable. The left lower leg showed tenderness over the knot and pain on percussion of the tibia at the distal part where he had the cystic knot on the lateral side. There was a firm cystic mass on the medial distal tibial area. The left ankle showed full ROM. The swelling was much decreased and almost gone. There was tenderness on the medial malleolar tip area. There was minimal discomfort on motion of the ankle. X-rays of the tibia-fibula was unremarkable. prescribed cyclobenzaprine and recommended obtaining a magnetic resonance imaging (MRI) of the left knee. The patient was to continue modified activity.

On May 8, 2014, noted that the patient's symptoms were no better. He had pain in the left MJL area. The left ankle was still sore, but not too bad. The swelling had gone down and it was only slightly swollen now. He had an MRI of the left knee that showed medial meniscal tear as well as degenerative changes and bone contusion. diagnosed meniscal tear, sprain/strain knee/leg unspecified site, knee contusion and sprain/strain of the ankle unspecified site. The patient was referred to an orthopedic surgeon and recommended to continue modified activity.

On May 15, 2014, an orthopedic surgeon, evaluated the patient for contusion of the lower leg. The patient's left ankle had improved. He had pain, swelling, popping, locking and giving away of the left knee. He reported no improvement with conservative care. X-rays done revealed no osseous defects, fractures, dislocations or arthritis. On examination, there was medial joint line tenderness and effusion of the knee. McMurray's test as well as Apley's test was positive. The ROM was decreased secondary to pain. diagnosed internal derangement of the left knee joint and acute tear of medial meniscus of the left knee joint. recommended operative arthroscopy and partial excision of acute tear of the medial meniscus. The patient was prescribed Ultram and naproxen.

Per utilization review dated May 21, 2014, the request for outpatient left knee arthroscopy was denied with the following rationale: *"This is a male with an xx/xx/xx date of injury, injuring his left knee and left ankle. May 15, 2014 initial orthopedic consultation revealed that the left ankle has improved. There was pain, swelling, popping, locking, and giving way of the left knee. He reports no improvement with conservative care. X-rays taken at the office revealed no osseous defect, fracture, dislocation or arthritis. Examination revealed medial joint line tenderness, effusion, and positive McMurray's. Range of motion was decreased secondary to pain. May 16, 2014 medical report identifies that an MRI was performed and it revealed a medial meniscal tear as well as degenerative changes and bone contusion. Diagnoses include internal derangement left knee and acute tear of medial meniscus, left knee joint. Treatment to date includes work restrictions, physical therapy, and medications. ODG criteria for meniscectomy include conservative care, at least two symptoms and exam findings consistent with meniscal pathology, and a meniscal tear on MRI. The patient has clinical findings compatible with meniscal pathology and has had appropriate conservative treatment without significant improvement. X-rays taken at the time of the May 15, 2014, orthopedic evaluation revealed no arthritis. However, the May 16, 2014 medical report identifies that an MRI was performed*

*and it revealed a medial meniscal tear as well as degenerative changes and bone contusion. The formal imaging report was not provided for review and it should be noted that orthopedic literature identifies that the severity of the osteoarthritic changes noted preoperatively, influences the clinical outcome of arthroscopic debridement of an osteoarthritic knee. Without the formal imaging report to clarify the current status of this patient's joint, including any possible degenerative findings and meniscal tear, the request cannot be considered medically appropriate. Therefore, recommend adverse determination. Peer to peer contact was unsuccessful."*

Per reconsideration review dated June 11, 2014, the appeal for outpatient left knee arthroscopy was denied with the following rationale: *"This is a male with a date of injury of xx/xx/xx after falling. The MRI of the left knee report dated May 6, 2014, revealed inferior articular surface tear posterior horn medial meniscus, mild tricompartmental osteoarthritis and chondromalacia, bone contusion to the medial and lateral femoral condyle and lateral tibial plateau, prominent superior and inferior patella enthesophytes with proximal patella tendinosis, a small joint effusion, mild medial collateral ligament (MCL) sprain and soft tissue edema. evaluated the patient on May 15, 2014, for left knee pain, popping, swelling, locking and giving way. Examination revealed positive McMurray and Apley testing and range of motion was decreased secondary to pain. stated that the x-rays showed no osseous defect, fracture, dislocation or arthritis. Diagnosis was internal derangement left knee, acute tear of the medial meniscus. The plan was for left knee arthroscopy, excision of acute tear of the medial meniscus left knee joint. The May 21, 2014 peer reviewer denied the surgery due to the findings of osteoarthritis and no formal imaging report provided. The patient has been treated with physical therapy, medications, work restrictions, ibuprofen, Flexeril and Ultram. The request for a left knee arthroscopy at this point would be not be recommended as medically necessary at this time pending further medical documentation or peer discussion. Based on current Official Disability Guidelines, it appears that there is evidence of imaging studies that show pathology of the meniscus as well as objective and subjective findings. It is unclear whether or not the conservative measures have truly been completed at this point. Attempts at peer discussion were unsuccessful."*

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

Left knee arthroscopy is not medically indicated. Radiographs documented degenerative arthritis about the knee. The medical records document persistent knee pain without mechanical complaints. There is no loss of motion (i.e. locked knee). He has been treated with anti-inflammatories, muscle relaxants, and physical therapy to the knee and ankle however there is no indication that injections have been provided. Based upon the lack of exhaustive care, no mechanical complaints, and underlying degenerative arthritis in this individual, arthroscopic debridement is not indicated and appropriate.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT**

**GUIDELINES--** Official Disability Guidelines, Treatment in Workers Comp 18th edition, 2013 Updates, Knee Chapter  
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 [e.g., 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).