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Notice of Independent Review Decision

July 21, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left knee arthroscopy with medial meniscal chondroplasty, partial meniscectomy, synovectomy, and possible microfracture bio gel injection, as an outpatient between 05/14/2014 and 06/28/2014.

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:

- Diagnostic studies (03/04/14)
- Office visits (03/14/14)
- Utilization reviews (05/13/14, 05/23/14)

- Diagnostics (04/14/11 - 03/04/14)
- Office visit (08/26/11 – 06/23/14)
- Procedure (10/29/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury to his left knee while at work on xx/xx/xx. He hit his left knee and caught himself with both hands before falling further.

On April 14, 2011, magnetic resonance imaging (MRI) of the left hip showed tear of the acetabular labrum anteriorly. There was probable tear of the lateral portion of the acetabular labrum. There was small cluster of paralabral cysts anteriorly. There was small focal protrusion or bulge of the cortex of the left femoral neck anterolaterally and this could predispose to femoroacetabular impingement. There was minimal tendinosis of the gluteus medius tendon attachment to the left greater trochanter.

On August 26, 2011, evaluated the patient for left hip pain and occasional catching in the left hip. The pain was all over the anterior aspect. The patient had some relief of his pain with an intra-articular injection but it only lasted approximately for two weeks. assessed left hip anterosuperior labral tear refractory to conservative treatment and left hip impingement. Surgery was recommended.

On October 15, 2013, x-rays of the left hip showed moderate osteoarthritis without fracture or subluxation. There was severe loss of superior joint space subjacent to the acetabular roof noted with extensive superolateral osteophytosis.

On October 18, 2013, MRI of the left hip showed small left hip joint effusion and tiny marginal spur in the left femoral head.

On October 21, 2013, the patient underwent laboratory tests. X-rays of the chest was unremarkable.

On October 23, 2013, evaluated the patient and opined that the patient had been determined to be low risk for the recommended procedure and anesthesia.

On October 23, 2013, saw the patient for preoperative visit for left total hip arthroplasty. The patient was a candidate for left total hip arthroplasty. X-rays of the left hip showed a grade 4 arthrosis of the left hip with periarticular osteophytosis. Surgery was recommended.

On October 29, 2013, performed left total hip arthroplasty.

On postoperative follow-ups in November, the patient was prescribed Keflex and Celebrex.

On November 29, 2013, noted the patient was feeling fatigue and had left index finger pain. The patient felt as if someone was stabbing his finger. He had numbness and tingling in the left index finger. The patient had left knee pain and swelling. He had undergone inpatient and was undergoing outpatient rehabilitation. He had left hip soreness, left thigh spasm and difficulty putting pressure on the left leg. He was utilizing hydrocodone and Viibryd. was trying to

get surgery on the left hand but it was not yet approved. Diagnosis was left hip labral tear, left knee internal derangement, left wrist internal derangement, left knee post surgical and left wrist post surgical. prescribed Viibryd and recommended follow-up for left knee.

On December 23, 2013, consent was obtained for left knee injection.

On December 30, 2013, the patient was referred for MRI of the left knee.

On March 4, 2014, magnetic resonance imaging (MRI) arthrogram of the left knee was performed for a history of left knee pain, especially with flexing and bearing weight for many years. The patient had multiple knee arthroscopies. The study revealed post meniscectomy changes within the posterior horn and the body of the medial meniscus. A 1-mm step-off filling with contrast at the inferior articular surface of the posterior body of the medial meniscus was seen on a single coronal image that was suspicious for a small recurrent/residual loss. A 1-mm focus of superficial partial-thickness cartilage fissure was noted at the posterior weightbearing medial femoral condyle. There was minimal tricompartmental degenerative changes without joint space narrowing, mild lateral tilting and lateral subluxation of the patella, grossly intact patellar articular cartilage, as well as the femoral trochlear groove cartilage.

On March 14, 2014, the patient was seen for complaints of knee pain. The patient reported falling onto his knee and developing moderate-to-severe pain that was aggravated by physical activity and associated with weakness. The patient admitted to joint stiffness, weakness, muscle aches and painful joints. History was positive for a knee scope in 2011. Medications included Celebrex and Viibryd. Examination showed pain over the medial aspect of the left knee, positive mild tenderness and positive McMurray's, mild crepitus about the patella and decreased range of motion (ROM) with pain. The diagnoses were knee pain, effusion of lower leg joint and tear of medial cartilage or meniscus of the knee. A left knee scope with MM chondroplasty, possible microfracture bio-gel injection was recommended and a preoperative follow-up was planned once the surgery was approved.

On March 14, 2014, saw the patient for night pain, paresthesias, numbness, dysesthesia, and radiating pains in the right upper extremity. The patient reported he awakens at night with numbness and paresthesia in the left upper extremity. recommended a nerve conduction velocity (NCV) study of the left upper extremity. The patient had evidence of a carpal tunnel syndrome (CTS) and possible median ulnar nerve compression in the left hand and wrist.

On April 22, 2014, saw the patient for left hip, left knee, left wrist, left finger and lumbar complaints. noted that opined that the patient was a candidate for tenosynovectomy and tenolysis of the left index finger. However the recommended surgery was denied.

On May 7, 2014, requested a left knee scope.

On May 12, 2014, noted the patient recently had a cortisone injection of the left GT bursa. The patient reported significant increase in pain level. The patient had not started physical therapy (PT). His left knee pain was worsening. The patient was awaiting approval for left knee arthroscopy.

Per utilization review dated May 13, 2014, the request for left knee arthroscopy with medial meniscus chondroplasty, partial meniscectomy, synovectomy and possible microfracture bio gel injection as an outpatient was denied with the following rationale: *“Based on the clinical documentation provided, the claimant failed to meet the criteria as outlined by the ODG. Specifically, the claimant had not completed a course of conservative management including physical therapy. Additionally, the changes of the medial meniscus on MRI are only noted on a single coronal image. As such, the requested operative intervention was considered not medically necessary and recommended for non-certification.”*

On May 13, 2014, a request for reconsideration was placed.

Per reconsideration review dated May 23, 2014, the request for left knee arthroscopy with medial meniscus chondroplasty, partial meniscectomy, synovectomy and possible microfracture bio gel injection as an outpatient was denied by

On May 23, 2014, upheld the denial with the following rationale: *“The patient is a male who sustained an injury to his left knee while at work on xx/xx/xx. The patient did undergo an MRI arthrogram of the knee on March 4, 2014, which showed post meniscectomy changes at the posterior horn and body of the medial meniscus along with partial-thickness cartilage fissure, weightbearing medial femoral condyle and minimal tricompartmental osteoarthritis. The patient was seen on March 14, 2014, at which time the patient was complaining of left knee pain. The patient had undergone left knee arthroscopy in 2011. The patient was taking Celebrex for pain. On physical examination, he was tender over the medial aspect of the left knee and medial joint line with positive McMurray’s and mild crepitation. was not able to determine the medical necessity of this request based on supportive guidelines. At this point, there was no indication the patient had undergone any recent conservative treatment such as PT and/or injection. Therefore based on the guidelines, the request was recommended for non certification.”*

In a letter dated June 15, 2014, stated that given the patient’s history of a failed cortisone injection and persistent symptoms of pain as well as mechanical symptoms of clicking, catching, and intermitted buckling, the patient was a considered a candidate for arthroscopic management with meniscectomy and occult loose body removal. An approval for the recommended left knee arthroscopic meniscectomy with possible loose body removal was recommended.

On June 23, 2014, noted the patient continued to have persistent pain in his left knee with associated clicking, catching and popping. The pain caused intermittent

buckling while walking. The patient was awaiting for surgery approval. His left hip bursitis had improved slightly from his cortisone injection however he still had not been approved for PT. He recently underwent surgery on his left hand. Examination of the left knee showed mild swelling, tenderness along the medial and posterior medial joint line, positive McMurray, decreased ROM. On left hip examination, there was tenderness to palpation along the GT bursa. Dr. provided a letter to support the request for seeking approval for left knee arthroscopy with meniscectomy. The patient was to continue home exercise program (HEP).

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

The requested surgical intervention is not considered as medically necessary. The available MRI is not consistent with this individual's complaints, it does not provide findings of support for any mechanical complaints. There is also a known history for this individual of multiple prior surgical procedures the details of which are not available. The information does not support a medical necessity for the requested procedure.

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, Knee and Leg chapter, updated 06/05/14

Hospital LOS

Arthroscopy (80.26 - Knee arthroscopy)

Actual data -- insufficient overnight stays

Best practice target (no complications) – Outpatient

Meniscectomy (81.43 - Knee repair)

Actual data -- insufficient overnight stays

Best practice target (no complications) – Outpatient

Synovectomy (80.76 - Synovectomy, knee)

Actual data -- median 5 days; mean 6.7 days (± 0.2); discharges 5,996; charges (mean) \$46,829

Best practice target (no complications) -- 5 days

Official disability Guidelines, Knee and Leg chapter, updated 06/05/14

Diagnostic Arthroscopy

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)

ODG Indications for Surgeryä -- 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).

Official disability Guidelines, Knee and Leg chapter, updated 06/05/14

Meniscectomy ODG Indications for Surgeryä -- 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).

Official disability Guidelines, Knee and Leg chapter, updated 06/05/14

Microfracture surgery (subchondral drilling)

ODG Indications for Surgeryä -- Microfracture surgery

Procedure: Subchondral drilling or microfracture. Requires all 4 below:

1. Conservative Care: Medication OR Physical therapy (minimum of 2 months). PLUS
2. Subjective Clinical Findings: Joint pain AND Swelling. PLUS
3. Objective Clinical Findings: Small full thickness chondral defect on the weight bearing portion of the medial or lateral femoral condyle AND Knee is stable with intact, fully functional menisci and ligaments AND Normal knee alignment AND Normal joint space AND Ideal age 45 or younger. PLUS
4. Imaging Clinical Findings: Chondral defect on the weight-bearing portion of the medial or lateral femoral condyle on: MRI OR Arthroscopy. (Washington, 2003)

Official disability Guidelines, Knee and Leg chapter, updated 06/05/14

Chondroplasty

ODG Indications for Surgeryä -- 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).