MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
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800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: September 17, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Knee Medial Meniscectomy

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

This case was reviewed by a physician who holds a board certification in Orthopedic Surgery and is currently licensed and practicing in the State of Texas.

REVIEW OUTCOME

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a male. He has complained of pain ever since the accident especially with weight-bearing. He was seen in the emergency department a few days later where x-rays were obtained, which were negative for subluxation/fracture. He was given Vicodin and diagnosed with a sprain of the left knee. On 07/23/2014 an MRI was performed which reported a radial tear of the medial meniscus near the junction of the body and the posterior horn without flipped or displaced fragments. There was a grade 1 sprain of the medial collateral ligament and small joint effusion with no intra or loose body. He was seen again on 07/25/2014 with continued left knee pain with associated swelling and was referred to orthopedic surgery, for further follow-up. On 08/06/2014, he was seen with complaints of shooting, aching, throbbing and constant left knee pain. Physical examination findings revealed joint line tenderness, questionable positive McMurray's sign and some mild swelling. At that time felt the patient was not a good candidate for physical therapy and recommended meniscectomy in the posterior half of the meniscus on the left knee. Seen again on 08/20/2014 there was no change in the patient's symptoms and

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conservative medications had not given the patient any relief. The surgery had been denied by peer review and refilled for surgery to be reconsidered.

The request for a left medial meniscectomy was denied because the documentation did not show evidence of conservative treatment to include physical therapy or home exercise.

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

The patient has been denied surgery previously as an adequate course of conservative treatment has not been documented. In my review of the supplied documentation, I was also not able to find evidence that the patient has undergone a home exercise program or any physical therapy as a conservative modality. The physician states in his assessment that this tear represents a block to range of motion, but the objective exam documents normal range of motion with medial joint line pain and a positive McMurray. The ODG would support forgoing physical therapy in the case of a mechanical block to motion (i.e. incarcerated bucket handle tear); however, this case involves a radial tear with normal range of motion. Thus, the ODG would require a trial of home exercise program versus trial of physical therapy prior to proceeding with arthroscopy and meniscectomy. Therefore, I would agree with the previous adverse determination.

ODG – Knee & Leg (Acute & Chronic)
Meniscectomy
Recommended as indicated below for symptomatic meniscal tears for younger patients and for traumatic tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings, or in older patients with degenerative tears until after a trial of PT/exercise. (Kirkley, 2008) Meniscectomy is a surgical procedure associated with a high risk of knee osteoarthritis (OA). One study concludes that the long-term outcome of meniscal injury and surgery appears to be determined largely by the type of meniscal tear, and that a partial meniscectomy may have better long-term results than a subtotal meniscectomy for a degenerative tear. (Englund, 2001) Another study concludes that partial meniscectomy may allow a slightly enhanced recovery rate as well as a potentially improved overall functional outcome including better knee stability in the long term compared with total meniscectomy. (Howell-Cochrane, 2002) The following characteristics were associated with a surgeon's judgment that a patient would likely benefit from knee surgery: a history of sports-related trauma, low functional status, limited knee flexion or extension, medial or lateral knee joint line tenderness, a click or pain noted with the McMurray test, and a positive Lachmann or anterior drawer test. (Solomon, 2004) Our conclusion is that operative treatment with complete repair of all torn structures produces the best overall knee function with better knee stability and patient satisfaction. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus

surgery will not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis, and meniscectomy will not improve the OA. Meniscal repair is much more complicated than meniscal excision (meniscectomy). Some surgeons state in an operative report that they performed a meniscal repair when they may really mean a meniscectomy. A meniscus repair is a surgical procedure done to repair the damaged meniscus. This procedure can restore the normal anatomy of the knee, and has a better long-term prognosis when successful. However, the meniscus repair is a more significant surgery, the recovery is longer, and, because of limited blood supply to the meniscus, it is not always possible. A meniscectomy is a procedure to remove the torn portion of the meniscus. This procedure is far more commonly performed than a meniscus repair. Most meniscus tears cannot be treated by a repair. See also Meniscal allograft transplantation. (Harner, 2004) (Graf, 2004) (Wong, 2004) (Solomon-JAMA, 2001) (Chatain, 2003) (Chatain-Robinson, 2001) (Englund, 2004) (Englund, 2003) (Menetrey, 2002) (Pearse, 2003) (Roos, 2000) (Roos, 2001) Arthroscopic debridement of meniscus tears and knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for all patients with knee osteoarthritis. (Siparsky, 2007) Asymptomatic meniscal tears are common in older adults, based on studying MRI scans of the right knee of 991 randomly selected, ambulatory subjects. Incidental meniscal findings on MRI of the knee are common in the general population and increase with increasing age. Identifying a tear in a person with knee pain does not mean that the tear is the cause of the pain. (Englund, 2008) Arthroscopic meniscal repair results in good clinical and anatomic outcomes. (Pujol, 2008) Whether or not meniscal surgery is performed, meniscal tears in the knee increase the risk of developing osteoarthritis in middle age and elderly patients, and individuals with meniscal tear were 5.7 times more likely to develop knee osteoarthritis. (Englund, 2009) AHRQ Comparative Effectiveness Research concluded that arthroscopic lavage for osteoarthritis, with or without debridement, does not improve pain and function for people with OA of the knee. (AHRQ, 2011) The repair of meniscal tears is significantly improved when performed in conjunction with ACL reconstruction. (Wasserstein, 2011) In patients with a nontraumatic degenerative medial meniscal tear and no knee osteoarthritis, arthroscopic partial meniscectomy is no better than sham surgery according to a high quality RCT. While arthroscopic partial meniscectomy is the most common orthopedic procedure performed in the U.S., rigorous evidence of its efficacy is lacking. While the results may argue against the current practice of performing arthroscopic partial meniscectomy in patients with a degenerative meniscal tear, the study did not compare meniscectomy with no treatment, because in the sham surgery group, they inserted an arthroscope and put fluid through the knee. (Sihvonen, 2013)
Physical therapy vs. surgery: In older patients with degenerative tears and symptoms caused by osteoarthritis, PT/exercise may be an appropriate first option and it may be possible to reserve surgery for those who do not benefit from PT alone. A high quality RCT, the Meniscal Tear in Osteoarthritis Research (METEOR) trial, found similar outcomes from PT versus surgery for meniscal tears in older individuals. Researchers at seven major universities and orthopedic surgery centers around the U.S. assigned 351

people with arthritis and meniscus tears to get either surgery or physical therapy, nine sessions on average plus exercises to do at home. After six months, both groups had similar rates of functional improvement, and pain scores were also similar. While 30% of patients assigned to physical therapy wound up having surgery before the six months was up, often because they felt therapy wasn't helping them, they ended up the same as those who got surgery right away, as well as the rest of the physical therapy group who stuck with it and avoided having an operation. These results suggest that physical therapy may be an appropriate first option for many patients with osteoarthritis and meniscal tears and that it may be possible to reserve surgery for those who do not benefit from physical therapy alone. (Katz, 2013) Another RCT comparing meniscectomy to strengthening exercises in patients presenting with degenerative medial meniscus tear and no clear evidence of osteoarthritis (Kellgren-Lawrence grade 0-1) found no significant between-group differences in function, pain, or patient satisfaction scores. (Yim, 2013) Arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical and medical therapy, according to the results of a single-center, RCT reported in the New England Journal of Medicine. The study, combined with other evidence, indicates that osteoarthritis of the knee (in the absence of a history and physical examination suggesting meniscal or other findings) is not an indication for arthroscopic surgery and indeed has been associated with inferior outcomes after arthroscopic knee surgery. However, osteoarthritis is not a contraindication to arthroscopic surgery, and arthroscopic surgery remains appropriate in patients with arthritis in specific situations in which osteoarthritis is not believed to be the primary cause of pain. (Kirkley, 2008) In this RCT, arthroscopic partial medial meniscectomy followed by supervised exercise was not superior to supervised exercise alone in terms of reduced knee pain, improved knee function and improved quality of life, after non-traumatic degenerative medial meniscal tear in ninety patients, mean age 56 years. (Herrlin, 2007) (Marcus, 2002) (Moseley, 2002) See also Arthroscopic surgery for osteoarthritis.

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

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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**

X **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)**