

# Vanguard MedReview, Inc.

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## IRO CASE #:

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

OP Right Knee Scope; ACL Repair, Partial Medial/Lateral Menisectomies & loose body removal 29888 29880 29874

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

This reviewer is a Board Certified Orthopedic Surgeon with over 42 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 who sustained a knee injury on xx/xx/xx when he fell off the back of a pickup truck while at work.

11/08/2014: CT Right Knee without contrast. **Impression:** 1. Mildly comminuted fracture along the posterior rim of the lateral tibial plateau. There are 2 linear fragments from the posterior rim the lateral tibial plateau which are mildly displaced superiorly into the posterior aspect of the lateral compartment of the knee. One of these linear fragments measures 9x2 mm. The second measures 6x1 mm. There is no significant depression of the articular surface of the lateral labial plateau. No fracture identified along the central or primary weight-bearing surface of the lateral labial plateau. 2. Large effusion. 3. Mild tricompartment osteoarthritis.

11/13/2014: Office Visit. **HPI:** The patient is a worker's compensation patient with a definite date of injury of xx/xx/xx. He was on the back of a pickup. The patient works on xx and says that he lifted something very heavy and it slipped off the

truck, came down on his knee, hyperextended it, and he heard and felt a big pop. The patient has acute swelling on the joint. He went to the ER and had X-rays. On CT scan the pt was found to have a lateral tibial plateau fracture that is nondisplaced. **Current Medications:** Norco for pain. **Physical Examination:** The patient has instability, nighttime pain, tingling, catching and decreased ROM and a joint effusion. The pain at this point is constant. The patient has been using ice and elevation and hydrocodone for pain. **Plan:** At this point we are going to get the patient set up for MRI of the knee. I am also worried about injury to the patient's anterior cruciate ligament with mechanism of injury with the acute swelling that he had. There is a possibility that the patient has injured the anterior cruciate ligament. So we will get a MRI and get a better look at the tibial plateau fracture and we will get him back in to see . Until then, the patient needs to be on crutches nonweightbearing and off of work. We placed the patient on Talwin for pain. That is Talwin NX, #60, one tablet every three to four hours as needed for pain.

12/02/2014: MRI of the right tibia/tibula. **Impression:** 1. Large complex joint effusion, debris and likely blood products present. Evidence for synovial thickening, mild synovitis also suggested. 2. Frank marrow edema within the tibial met diaphysis and epiphysis, complex pattern, suggestive of both high-grade stress injury involving the tibial metaphysis, and also subchondral frank marrow edema extending from the posterior lateral tibia that may be related to macro fracture involving the posterior lip of the tibia. Along with subtle confusion in the lateral femoral condyle findings are suspect for associated pivot shift injuries related to ACL injury, which is thought likely intermediate to high-grade (given the presence of the contusions more likely high grade). Please correlate clinically. 3. Additional marrow edema within nonweightbearing aspect lateral femoral condyle, could be secondary to above versus direct contusion. 4. Substantive marrow edema within the trochlea just lateral to the groove, could be secondary to atypical impaction phenomenon or grade 4 chondromalacia. Evidence for grade 3 to early grade 4 chondromalacia noted also lateral compartment. Grade 4 patellar chondromalacia also present. 5. Very mild periligamentous increased signal associated with the MCL mid to proximally, favor low grade MCL injury. 6. Focal hypo intensity at proximal aspect of the LCL, fibular collateral component, correlation with plain films recommended, could represent calcification associated with prior trauma. 7. Linear somewhat serpiginous signal within the tibial metaphysis and epiphysis posteriorly extends to PCL insertion region and could be related to enthesopathic changes. 8. Low-grade injury distal PCL. 9. High riding patella, slight lateral patellar subluxation. 10. Trivial bursal prolapse.

12/09/2014: Office Visit. Patient presents for MRI results of right knee. **Physical Exam:** The patient said the pain continues and there is really no change. He cannot bend the knee at all without considerable pain. **Plan:** At this time we are going to try to get the patient set up for a right knee scope with removal of the loose bodies secondary to the tibial stress fracture, anterior cruciate ligament reconstruction, and partial medial and lateral Menisectomies. This will all be done through the scope and this was the only thing that really stands a chance of getting the patient back to full duty at work having a torn anterior cruciate

ligament, it will never be stable and he will never be able to put all his weight on it and he will just continue to tear it hurting it worse and could put himself and anyone he is working with in danger The loose bodies are from the fracture of the high-grade stress fracture. We know osteochondral loose bodies can form after a tibial plateau fracture very easily. These are just going to continue to wear away the cartilage and cause the patient a lot of pain. We will try to get him set up for that surgery.

01/13/2015: UR. **Rationale for Denial:** The patient is a male who injured his right knee on xx/xx/xx when he fell. The patient is diagnosed with right lateral tibial plateau fracture and internal knee derangement. A request for right knee scope, anterior cruciate ligament repair, partial medial/lateral meniscectomy, and loose body removal has been made. CT scan of the right knee by dated 11/08/2014 showed mildly comminuted lateral tibial plateau fracture, effusion, and mild tricompartmental osteoarthritis. MRI of the right tibia/fibula by dated 12/2/14 showed large effusion, high grade anterior cruciate ligament and tibial metaphysis injury, lateral femoral condyle marrow edema, grade 4 chondromalacia, low grade medial collateral ligament injury, LCL calcification, low grade PCL injury, and slight lateral patellar subluxation. The patient was initially treated with medications and bracing which provided some relief. The recent medical record dated 12/9/14 indicates that the patient complains of right knee pain. Current medication includes hydrocodone. Physical examination revealed medial and lateral joint line pain with tenderness over the posterior tibia. McMurray's test is positive on the right. While the patient complains of right knee pain, there is no recent comprehensive clinical evaluation of the patient from the treating physician that addresses the proposed surgery. Also, updated imaging studies of the right knee indicating fracture healing were not submitted for review prior to surgery. Moreover, there was no evidence in the medical reports submitted that the patient has exhausted physical therapy. In consideration of the foregoing issues and the referenced evidence-based practice guidelines, the medical necessity of the requested surgery has not been established.

01/15/2015: Office Visit. **HPI:** The surgery was denied by WC stating that the patient has not exhausted conservative measures, such as physical therapy. **Plan:** Order physical therapy. We do not anticipate him being able to do it secondary to pain and the anterior cruciate ligament tear that he has, but we will order for ROM and strength, and see the patient back after that. If he fails, we will resubmit for surgery at that time, given that that would then address the conservative therapy measures that we try first before surgery.

01/20/2015: Physical Therapy Initial Evaluation. **Subjective:** Pt reports injury to his knee when he fell off of the tailgate of his truck. He states that he twisted his knee when he landed and that he has not gotten any better since the accident. He states that he is going to have to have surgery to get better. **PmHx:** HTN **Medications:** Hydrocondone, Lisinopril, Flexeril **Pain rating:** 8/10 on VAS described as sharp/stabbing that is worse with walking. **Functional limitations:** Pt is unable to work, has a dependent gait and is limited in ADL's and recreational activity. Patient goals: return to work. **APROM:** Flexion: Right 110/122 Left: 135.

Ext: Right: -20/-11 Left: -5 **MMT:** Flexion: Right: 4- Left: 5 Ext: 4- Left: 5 **Edema:** Joint Line: Right 40.5 cm Left: 39.5cm Gait: Antalgic using bilateral axillary crutches NWB on involved extremity. Functional Outcome tool: Lysholm Knee rating 6/100. G-code modifier CM 94% impairment **Assessment/Plan:** Pt presents 10 wk s/p right knee injury that is not resolving. Subsequently he has decreased ROM, weakness, an abnormal gait pattern and significant pain. Pt may benefit from skilled PT to address the above deficits with therapeutic exercises, HEP, manual therapy and modalities in preparation for a future surgery. Pt to be seen 2 x weeks for 4 weeks.

02/05/2015: Office Visit. **HPI:** The patient is back in after failing PT for his right knee. **Physical Examination:** WC denied surgery so pt was set up for pt, which he has now been dismissed from pt by the physical therapist who said the patient is getting worse rather than better. Today, pt lacks 10 degrees to full extension. He has 90 degrees of flexion. Basically his knee is locked up and really cannot get anymore motion. The patient is on crutches and cannot walk. He has a joint effusion. With examination, the pt has positive anterior drawer, positive Lachman, positive McMurray's with medial joint line pain. When asked where he hurts, he points to the medial joint space as if he has a medial meniscus tear that is caught and out of position. The pt was also shown to have an intermediate to high-grade injury to his anterior cruciate ligament. He had noted marrow edema of the lateral femoral condyle and this was secondary to the contusion that he sustained at the time of his injury. **Plan:** Right knee arthroscopy with anterior cruciate ligament reconstruction. The pt needs partial medial and lateral Menisectomies and removal of osteochondral loose bodies and debris.

03/10/2015: Office Visit. **Physical Exam:** The pt has a full thickness tear of his anterior cruciate ligament. His ROM continues to get worse. He now lacks 15 degrees to full extension. The patient cannot even get it fully flexed to 90 degrees which he was able to do at his last visit a month ago. He is still on crutches. The pt has constant joint effusions. It gives out on him often. The pt has already had pt and has failed that. He continues to fall and in fact he just fell this morning. The effusion is getting worse and the pain as well as his ROM is getting significantly worse. The pt is ready to get fixed so he can get better and go back to work. The anterior cruciate ligament is the biggest stabilizer of his knee and with the tear and WC continuing to allow the patient to walk on this tear, it is just tearing it more, which is confirmed by him continuing to fall more and more. **Plan:** We have given the patient Norco 7.5/325 milligrams, #90 one to two every six to eight hours as needed for pain with no refills. We have filled out the pt TWCC form to keep him off work. We told him we would call him once WC lets us know. We will continue to work for the pt.

03/11/2015: UR. **Rationale for Denial:** The patient is a male who "lifted a heavy object that fell over his knee causing him to hyperextend his knee" or "fell off the tailgate of his truck" on xx/xx/xx. He is diagnosed with right lateral tibial plateau fracture and internal knee derangement. An appeal request was made for a right knee arthroscopy with ACL repair, partial medial/lateral meniscectomy, and loose body removal. The initial request was not justified due to lack of recent

comprehensive clinical evaluation to address the proposed surgery, lack of an updated imaging study to show fracture healing, and lack of documented exhaustion of physical therapy. The submitted records now include the 01/20/2015 initial physical therapy evaluation report and 02/05/2015 follow-up visit report. He has received treatment in the form of medications, rest, bracing, assistive device for ambulation, decreased weight bearing, HEP, and PT. A right knee CT by on 11/08/2014 showed a mildly comminuted lateral tibial plateau fracture, 2 linear fragments which are displaced superiorly, effusion, and mild tricompartmental osteoarthritis. Per the 11/13/14 report, he had instability, nighttime pain, tingling, catching, decreased ROM, and joint effusion. An MRI of the right tibia/fibula by on 12/02/2014 showed effusion, synovial thickening, synovitis, marrow edema, suggestion of high-grade stress injury involving the tibial metaphysis and macro fracture involving the posterior lip of the tibia, pivot shift injuries related to ACL injury, chondromalacia, low grade MCL injury, possible calcification at the proximal LCL, suggestion of enthesopathic changes, distal PCL injury, high riding patella, lateral patellar subluxation, and bursal prolapse. The 12/9/14 report states that hydrocodone has helped with the pain. He continued to use his crutches due to feeling very unstable. On 1/20/15, he was evaluated for physical therapy. Right knee findings include 110-112 degrees flexion, -11 to -20 degrees extension, and strength of -4/5. He presented on 02/05/2015 with right knee pain. He has had two falls and was getting worse. PT for the right knee has failed. He was dismissed by the physical therapist who said that the patient was getting worse rather than better. He lacked 10 degrees to full extension. Flexion was 90 degrees. His knee is basically locked up. He was on crutches and could not walk. He had joint effusion. Anterior drawer, Lachman's, and McMurray's tests were positive. Medial joint line tenderness was present. X-rays reviewed on that day showed no significant collapse. The updated documentation was unable to address one of the previous reasons for denial. Although the patient has effusion and locking of the knee which precludes conservative care and imaging evidence for the requested surgery, there was still no fracture healing seen on the recently reviewed x-rays. In agreement with the previous UR determination, the medical necessity of this request has still not been validated. Given the above, the request for Appeal request for OP Right Knee Scope; ACL Repair, Partial Medial/Lateral Menisectomies & Loose Body Removal 29888 29880 29874 is non-certified.

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

The previous adverse determinations are upheld. The patient's records indicate an injury to his right knee on xx and CT scan shows a lateral tibial plateau fracture. MRI shows injury to the knee, but isn't specific on the condition of the ACL or either meniscus or presence of loose bodies. He had physical therapy without relief which would be expected for a tibial plateau fracture. It is obvious that he sustained a significant knee injury. I think needs to pin down the diagnosis better by getting a reading of the MRI to describe the condition of the ACL, and both menisci. With the records available the only clear diagnosis is the lateral tibial plateau fracture, bone contusions and arthritis. The treatment for this

would not be ACL reconstruction and/or meniscectomy. Based on the records available I would have to deny the requested surgery. For these reasons, OP Right Knee Scope; ACL Repair, Partial Medial/Lateral Meniscectomies & loose body removal 29888 29880 29874 should be denied.

Per ODG:

**ODG Indications for Surgery™ -- 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).

**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)