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February 10, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left arthroscopy, 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 Board Certified Doctor of Orthopedic Surgery with over 18 years of experience

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Partially Overturned (Agree in part/Disagree in part)
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]:
XXXX: Office Notes by XXXX. **HPI:** Patient presents for follow-up of pain in the right knee which was originally seen on XXXX. Original onset was XXXX. Patient reports pain developing to the right knee without injury on XXXX with pain increasing then while at work and at home. Then XXXX at work on XXXX and felt a pop behind the right knee with an immediate increase in pain and not being able to bear weight. The XXXX then came to XXXX and gave XXXX crutches. (XXXX Note) Since last visit pt has been working with restrictions, using knee immobilizer had crutched with weight-bearing as tolerated. States pain not much better now than last visit. Rates pain 7/10, worse with weight bearing and ROM. **Diagnosis:** Sprain of other specified parts of right knee, subsequent encounter. **Medication orders:** Tylenol-codeine #3. 1 tab four times daily. **Plan:** Return XXXX.

XXXX: MRI Right Knee WO Contrast interpreted by XXXX. **Impression:** 1. Degeneration/partial tearing at the posterior root ligament of the medial meniscus. Mild extrusion of the body. 2. Myxoid degenerative change in the anterior horn and root ligament of the lateral meniscus. 3. Abnormal ACL appearance. Favor ACL interstitial ganglion cystic change. Mucoid degeneration and low grade sprain considered less likely. 4. Grade 1 MCL sprain could be considered. 5. Mild arthropathy. Grade 2 medial tibiofemoral chondromalacia. Grade 2/3 chondromalacia patellae. 6. Small joint effusion with no intra-articular body. 7. No bone contusion, stress change or fracture.

XXXX: Office Notes by XXXX **HPI:** XXXX presents for new RT knee problem, here with x-ray and MRI results. Pain began XXXX. Patient is a XXXX, pain caused by XXXX. All use of the knee increases pain medication and ice somewhat improves pain. **Physical Exam:** ambulates with no assistive devices and limp. Knee: Inspection right: no deformity, mass, induration, warmth, or erythema

and normal axial alignment and swelling: mild effusion. Inspection left: no deformity, mass induration, warmth, erythema, or swelling and normal axial alignment. Bony palpation. Right: tenderness of the lateral patellar facet, the medial patellar facet, the inferior pole patella, the superior pole patella, and the medial joint line and no tenderness of the lateral joint line. Tenderness of the medial collateral ligament. Soft pain at extreme limits of range. Hamstring weakness and quadriceps weakness. Flexion 5/5 extension 5/5. **Assessment/Plan:** Medial meniscus tear. **Plan:** I had a long discussion with the patient about treatment options both conservative vs. operative. The patient desires surgical treatment.

XXXX: UR performed by XXXX **Rationale for Denial:** This is a case of a XXXX patient who sustained an injury on XXXX due to XXXX and XXXX. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced, this request is non-certified. There was no clear evidence if the patient had exhausted all types of conservative treatments such as physical therapy home rehab exercises and medication or activity modification prior to considering surgery as there was no documented objective response for medication or physical therapy. There were also no PT notes submitted for review. Exceptional factors were not identified to warrant the service requested. Given the lack of support, the request is not substantiated at this time.

XXXX: Office Note by XXXX **Assessment/Plan:** Patient was denied surgery for XXXX R knee. Request for R knee cortisone injection.

XXXX: Progress Note by XXXX **Treatment:** Cortisone injection given today **Plan:** Follow up in one month.

XXXX: UR performed by XXXX. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. As the clear evidence of conservative management such as physical therapy or home rehab exercises and home medication or activity modification was not still fully established in the medical records. There were still no PT reports submitted to objectively validate exhaustion and failure from the low levels of care. A detailed objective evidence of a recent, reasonable and/or comprehensive non-operative treatment trial and failure should be considered prior to considering higher levels of care. The previous denial is upheld. Thus, the request is not supported.

XXXX: Progress Notes by XXXX **HPI:** Pt returns to clinic for pain in XXXX right knee. XXXX had cortisone injections previously and has been in PT. No improvement. Here for surgery discussions. **Exam:** Right knee pos McMurrays, medial joint line tenderness, slight effusion, 0-120, pain with full flexion, no skin lesions, pulses 2+, stable, 5/5 strength.

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

The request for partial meniscectomy of the right knee is approved, in part.

This patient is a XXXX who sustained a XXXX in XXXX. The XXXX MRI demonstrated a partial tear of the medial meniscus with mild medial compartment osteoarthritis. XXXX was prescribed physical therapy for XXXX condition (2-3 x/week for 4-6 weeks). XXXX also received a cortisone injection to the knee. In XXXX, XXXX continued to have pain and swelling in the knee. On examination, XXXX was noted to have a positive McMurray's sign with medial joint line tenderness. The treating physician recommended arthroscopy of the knee to address XXXX meniscal tear.

The Official Disability Guidelines (ODG) supports partial meniscectomy in patients who have objective and subjective findings associated with a meniscal tear identified on an advanced imaging study.

Surgical candidates have failed a course of physical therapy. The ODG recommends nine sessions of physical therapy over eight weeks for non-surgical treatment of meniscal tears.

Surgery would be appropriate for this patient, if XXXX remains symptomatic once XXXX completes the recommended nine sessions of physical therapy.

Per ODG:

ODG Indications for Surgery™ -- Meniscectomy:
Criteria for meniscectomy or meniscus repair (It is recommended to require 2 symptoms and 2 signs to avoid arthroscopy with lower yield, e.g., pain without other symptoms, posterior joint line tenderness that could signify arthritis, or MRI with degenerative tear, which is often a 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 giving 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 when above criteria are met). (Washington, 2003b)
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)**