

# Parker Healthcare Management Organization, Inc.

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**DATE OF REVIEW:** FEBRUARY 20, 2018

**IRO CASE #:** XXXX

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

Medical necessity of proposed Left Knee Arthroscopy and Arthrotomy (29880)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Orthopedic Surgery and is engaged in the full time practice of medicine.

**REVIEW OUTCOME**

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

Upheld (Agree)

Xx Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a XXXX, who was injured on XXXX, in a XXXX. The claimant was diagnosed with acute neck strain, contusion of the left knee, and a strain of the left trapezius and right trapezius. There was MRI evidence of medial/lateral meniscal tearing, as well as underlying arthritis. There was grade IV cartilage thinning and osteophyte formation. Treatment included a corticosteroid injection with minimal pain relief. McMurray's was positive. Swelling was noted with pain on physical examination. An evaluation on XXXX, documented the claimant's symptoms were not in the patellofemoral joint. The clinician indicated the pathology was located in the site of the lateral medial meniscus and was thought to be unrelated to the tricompartmental underlying degenerative changes. Medications included ibuprofen. The MRI itself on XXXX, documented lateral patellar pole marrow T2 hyperintensity representing a contusion or subchondral reactive marrow change. There was lateral meniscal anterior horn large tear possibly extending into the anterior root ligament with probable anterior horn and body tear as well. There was a suspected medial meniscal anterior body tibial surface tear with possible anterior root ligament tear. There was moderate-to-severe patellofemoral compartment degenerative change with mild-to-moderate medial compartment degenerative change. There was a small region of severe chondromalacia of the lateral femoral condyle.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

## **RATIONALE:**

Arthroscopy for partial meniscectomy would be supported. There is meniscal pathology on MRI with persistent mechanical pain complaints. There was medial joint line tenderness on physical examination and positive McMurray's testing. Minimal improvement was noted with injection, physical therapy, and medications. The guidelines do not support arthroscopy for underlying degenerative changes, however, there was a trial and failure of lower levels of care and there is meniscal pathology on MRI consistent with physical examination findings. The request for a left knee arthroscopy and arthrotomy is certified.

Official Disability Guidelines Treatment Integrated Treatment/Disability Duration Guidelines Knee and Leg (Acute and Chronic) (updated 01/30/18) Meniscectomy Recommended as indicated below for symptomatic meniscal tears in younger patients, primarily for traumatic tears. Not recommended for osteoarthritis (OA) in the absence of solid mechanical meniscal findings or in older patients with degenerative tears who are more appropriately treated with physical therapy/exercise. (Kirkley, 2008) (Khan, 2014) See Meniscal allograft transplantation. See also Arthroscopic surgery for osteoarthritis; Loose body removal surgery (arthroscopy). 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). Risk versus benefit: The advantage of most surgery to treat meniscus tears appears to be limited to short-term relief of pain and mechanical catching, but not prevention of eventual osteoarthritis. Due to loss of meniscal cushioning following acute traumatic tears with or without additional removal of meniscal tissue (partial meniscectomy), OA progression simply becomes inevitable. Primary surgical repair of meniscus tears when feasible offers the best hope of joint preservation, but is associated with the risks of slower recovery and a relatively high re-tear rate often requiring additional surgery. The benefit of surgery for atraumatic tears or in the presence of significant OA drops off dramatically and may even be harmful, further accelerating OA progression. The ideal patients for meniscus surgery are younger, with smaller or repairable traumatic tears associated with mechanical symptoms, and no associated OA. Due to the unsolved issue of OA progression despite surgery, many indications for surgery in the past are now being strongly questioned. Meniscectomy is a surgical procedure associated with a high risk of knee osteoarthritis (OA). The long-term outcome of meniscal injury with or without surgery appears to be determined largely by the size and type of tears, and partial meniscectomy has better long-term results than subtotal meniscectomy. (Englund, 2001) Partial meniscectomy allows a slightly enhanced recovery rate as well as a potentially improved overall functional outcome including better knee stability, compared with total meniscectomy. (Howell-Cochrane, 2002) The following characteristics were associated with a surgeon's judgment that a patient might 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 Lachman or anterior drawer test. (Solomon, 2004) 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 are not as beneficial for older patients exhibiting signs of degenerative changes consistent with OA, and meniscectomy will not improve OA. Meniscal repair is much more complicated than meniscal excision (meniscectomy). Surgeons sometimes state in operative reports that they performed a meniscal repair when they really mean a simple meniscectomy. A meniscus repair actually reconstructs and saves the damaged meniscus, restoring normal knee anatomy, and this procedure has a much better long-term prognosis when healing is successful. However, meniscus repair is a more significant surgery with a longer recovery, and due to a limited blood supply to the meniscus, the procedure is not always technically feasible. Partial meniscectomy simply removes the torn portion of the meniscus and is far more commonly performed than meniscal repair. The majority of meniscus tears cannot be repaired. (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 for knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for most patients with knee osteoarthritis. (Siparsky, 2007) Asymptomatic meniscal tears are common in older adults, based on MRI scans of 991 randomly selected, ambulatory subjects. Incidental meniscal findings on MRI of the knee are common in the general population 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)

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

- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
  
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES