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May 23, 2018 – Amended May 25, 2018

Description of the service or services in dispute:

Left knee arthroscopy, meniscectomy and chondroplasty
29880 - Arthroscopy of knee surgical, with meniscectomy medial and lateral
29870 - Arthroscopy of knee, diagnostic
29881 - Arthroscopy of knee, surgical, with meniscectomy medial or lateral
29877 - Arthroscopy of knee, surgical, with shaving of articular cartilage
29875 - Arthroscopy of knee, surgical, with limited synovectomy

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified Orthopedic Surgery

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

☐ Overturned (Disagree)

☐ Upheld (Agree)

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

Patient Clinical History (Summary)

XXXX is a XXXX who was diagnosed with left knee pain (M25.562).

On XXXX, XXXX, injuring left knee.

On XXXX, XXXX was assessed by XXXX (Orthopedic Surgery) for left knee pain. The pain was constant, sharp, aching, and burning in intensity. The pain was 7-9/10 in severity. The aggravating factors included sitting / arising out of chairs, stairs, change in direction, on full extension / flexion, at night and with every step. The associated symptoms included popping, catching, swelling and weakness. Examination revealed tenderness in the medial / lateral joint line and superolateral aspect of the patella. Active range of motion was limited by pain. There was pain with passive range of motion and end ranges of motion. McMurray medial and lateral joint line test was positive. The assessment included knee pain, knee sprain, medial meniscus tear and mild-to-moderate osteoarthritis. Per note, XXXX had failed all conservative treatment and / or has pathology that would benefit from surgery; and therefore, surgery was medically necessary. XXXX had done abundant exercises since XXXX with XXXX knee, and it was difficult to continue due to pain. XXXX continued to have severe painful mechanical symptoms.

Treatment to date consisted of medications (XX, XX, XX and XX or XX), three XX injections (no change in condition), physical therapy (little improvement in the beginning, but no help at the time) and arthroscopy on XXXX. Ankle stabilizing orthotic (ASO) brace was provided for ankle instability.

An MRI of the left knee dated XXXX revealed posterior horn medial meniscus (PHMM) tear, anterior cruciate ligament sprain, a small suprapatellar joint effusion, grade 1 chondromalacia patella and mild-to-moderate tricompartmental degenerative changes. There was a large Baker's cyst seen. X-rays of the left knee dated XXXX were normal for age.

Per a utilization review dated XXXX by XXXX (Orthopedic Surgery), based on the clinical information submitted for the review and using the evidence-based peer-reviewed guidelines, the requested service was denied. Per the evidence-based guidelines, surgery was indicated in patients with pertinent subjective complaints and objective clinical findings corroborated by imaging studies after the provision of conservative care. XXXX had been recommended surgery; however, objective clinical findings as well as significant functional limitations were insufficient to support the procedure. In addition, imaging clinical findings were limited to support the request. There was no evidence of a large unstable chondral defect on MRI. The records were limited to validate if the patient had tried and failed indicated conservative treatment prior to the consideration of surgery. There were no actual physical therapy notes submitted for review. A clarification was needed regarding the request and how it might affect XXXX clinical outcomes. Clear exceptional factors could not be identified.

Per a utilization review dated XXXX by XXXX (Orthopedic Surgery), based on the clinical information submitted for the review and using the evidence-based peer-reviewed guidelines, the requested service was denied. There were ongoing findings of arthritis in the knee.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG recommends meniscectomy when there has been a failure of conservative care, there are complaints of pain and swelling, objective findings of joint line tenderness, a positive McMurray sign, and imaging findings of a meniscus tear on MRI. The ODG recommends diagnostic arthroscopy when there is inconclusive imaging following a minimum of XX of conservative treatment. The ODG recommends chondroplasty when there is a large unstable chondral defect on MRI. The ODG recommends synovectomy for synovitis or medial plica syndrome following a failure of six weeks of conservative treatment. The provided documentation indicates persistent left knee pain, swelling, popping, catching and weakness despite conservative treatment with multiple steroid injections, physical therapy and NSAIDs. There are physical examination findings of medial joint line tenderness, restricted active range of motion due to pain, full passive motion positive, and McMurray's medial and lateral testing. A left knee MRI from XXXX revealed a tear of the posterior horn of the medial meniscus, mild-to-moderate degenerative change, a small joint effusion and a large Baker's cyst. Due to the failure to improve with extensive conservative treatment, subjective complaints of pain and swelling, subjective mechanical symptoms, objective findings of joint line tenderness, a positive McMurray's test, and a medial meniscus tear on MRI, a partial medial meniscectomy is indicated, but there is no support for a partial lateral meniscectomy. There is a definitive diagnosis on MRI and there is no indication why diagnostic arthroscopic is necessary. In addition, diagnostic arthroscopy is typically bundled in the CPT code for meniscectomy. There is no evidence of a large unstable chondral defect to support the requested chondroplasty and there is no indication of synovitis or a medial plica to support the limited synovectomy.

Based on the provided documentation, the arthroscopy of the knee with medial or lateral meniscectomy (29881) is medically necessary, but the remaining requested procedures are not medically necessary.

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A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers

☐ Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain

☐ Interqual Criteria

☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards

☐ Mercy Center Consensus Conference Guidelines

☐ Milliman Care Guidelines

☑ ODG-Official Disability Guidelines and Treatment Guidelines
Knee and Leg Chapter
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)

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).

Diagnostic arthroscopy- Recommended as indicated below for symptomatic non-arthritic knee conditions following appropriate conservative care. Second look arthroscopy is only recommended for complications following osteochondral autograft transplant system or autologous chondrocyte implantation procedures or for individual cases that are ethically defendable for scientific reasons, only after a thorough and full informed consent procedure. (Vanlauwe, 2007)

ODG Indications for Surgery™ -- Diagnostic arthroscopy:
Criteria for diagnostic arthroscopy:
1. Conservative Care: A minimum of 6 weeks, including medications AND/OR physical therapy AND/OR bracing. PLUS

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2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS
3. Imaging Clinical Findings: Inconclusive imaging AND absence of moderate-to-severe arthritic changes. (Washington, 2003b) (Lee, 2004)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

ChondroplastyRecommended rarely as indicated below. Not recommended as a primary treatment for osteoarthritis or as an isolated procedure (unless large unstable chondral flap on MRI with definite mechanical symptoms), since arthroscopic surgery for knee osteoarthritis and articular chondral degeneration offers no added benefit to optimized physical therapy and medical treatment. (Kirkley, 2008) A quality RCT comparing debridement vs. simple observation of unstable chondral lesions encountered during arthroscopic partial meniscectomy resulted in no differences of 1-year outcomes. The authors suggested that debridement added no benefit and that such lesions should be left in situ. (Bisson, 2017)

ODG Indications for Surgery™ -- Chondroplasty:
Usually combined with other indicated knee procedures rather than as a stand-alone procedure
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. AND Mechanical catching. PLUS
3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS
4. Imaging Clinical Findings: Large unstable chondral defect on MRI.
(Washington, 2003b) (Hunt, 2002) (Janecki, 1998)

Synovectomy- Recommended as indicated below for specific conditions. Not recommended as a primary treatment for osteoarthritis or as an isolated procedure (unless specific criteria are met, e.g., medial plica syndrome), since arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical therapy and medical treatment.

ODG Indications for Surgery™ -- Synovectomy:
Synovectomy is usually combined with other indicated knee procedures rather than being performed as a stand-alone procedure, except for specific medical conditions reviewed below.
Criteria for synovectomy, requiring ALL of the following:
1. Conservative Care: A minimum of 6 weeks including Medications including failed corticosteroid injection (unless contraindicated). AND/OR Physical therapy. AND/OR Bracing. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS Joint pain. AND Swelling. PLUS
3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS
4. Imaging Clinical Findings: Absence of moderate-to-severe arthritic changes on X-ray or MRI.
For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)

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☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.

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