

**CALIGRA MANAGEMENT, LLC
344 CANYON LAKE
GORDON, TX 76453
817-726-3015 (phone)
888-501-0299 (fax)**

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX

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

Orthopedic Physician

REVIEW OUTCOME:

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

X 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 patient is a XXXX who sustained an injury on XXXX. XXXX XX XX XX and XX in XXXX XX XX.

On XXXX, the patient was seen by XXXX for postinjury XX XX pain. On exam, there was XX XX XX line tenderness and an XX and XX XX consistent with a positive XX XX. The x-XX of the XX showed some mild XX of the XX XX, might be 10-15% was slight flattening but no major osteoarthritic findings were noted. The MRI performed outside showed an unstable horizontal XX XX of the XX XX starting at the XX all the way around the XX XX. XXXX recommended XX arthroscopy for "XX XX XX."

On XXXX performed XX XX arthroscopic XX XX XX and an "XX" XX and drilling XX of the

XX XX XX. The postoperative diagnosis was an XX XX of the XX XX with XX XX XX plus an area of XX on the XX XX XX. In the body of the operative report, XXXX noted "damage on the XX XX XX," but XXXX did not discuss or otherwise specify any criteria for determining whether the XX was XX or XX.

On XXXX recommended the patient to remain XX-XX for five weeks postop; followed by XX-XX XX for one more week and then progress to weightbearing for the course in the next two weeks. Physical therapy (PT) was recommended.

On XXXX, the patient underwent initial PT evaluation at XXXX the patient attended XX PT sessions consisting of XX re-education, XX therapy and XX XX. Per the discharge summary dated XXXX, the patient was XX with an XX device. Minor XX XX was noted. On exam, the patient rated the pain at XX/10. XX extension mobility XX XX exercises were performed and the patient tolerated well. A home exercise program was recommended. The patient was XX from the PT because of XX.

On XXXX the patient reported XX of the XX and a XX XX of the XX for XX weeks. The patient had an episode where XXXX had to XXXX and had some pain in the XX XX. XXXX had been compliant starting to go full weightbearing but using the XX at the time of the visit. PT was helping. On exam, XXXX noted the patient XX about XX-XX degrees of XX XX, but it was easy to bend the XX to XX degrees. Minimal warmth and no large XX was noted. The patient was about XX full X during the day. XXXX cautioned the patient against any XX XX or XX for too long and recommended elevation and ice application. XXXX was prescribed.

On XXXX noted the patient continued XX XX with the fair amount of pain. However, the patient was making progress as compared to XX month ago. XXXX had trouble gaining full extension and had been going through PT. However, XXXX had completed only XX sessions as XX XX had been difficult and did not approve PT request. On exam, the patient XX about XX-XX degrees of XX XX, but XXXX was XX about XX. The XX was XX, the XX seemed to be stable. XXXX opined the patient was making slow progress, but XXXX clearly was not ready to XX XX hours a day at work and recommended PT three days a week for three more weeks. XXXX was added.

On XXXX noted the patient did not receive PT in five weeks due to denial. The patient was using a XX while XX. XXXX had pain, XX and XX in the XX XX. XXXX noted the patient lacked about XX XX of XX XX and was XX up to XX XX. An MRI was ordered.

On XXXX, an MRI of the XX XX revealed XX of the XX XX of the XX XX with XX XX into the XX XX. XX XX was present with prominent XX XX deep to XX XX involving the medial

XX XX.

On XXXX, a preauthorization was requested for XX XX XX versus total XX XX.

On XXXX completed a utilization review. The request for the XX XX XX versus total XX XX as an inpatient (unspecified number of days) for symptoms related to XX XX-XX XX of the XX XX was denied. Rationale: *"The request is for XX XX XX versus XX XX arthroplasty as an inpatient. I have not been able to determine the medical necessity. At this point, there is no indication that the claimant has undergone any conservative treatment and there is no documentation that the claimant has XX changes and therefore based on the guidelines, the request is recommended for noncertification."*

On XXXX appealed the denial. XXXX stated: *"The denial reasoning states XXXX could not determine the medical necessity due to there is no indication that the patient has undergone conservative treatment and there is no documentation that the patient has XX changes. Per the office notes on XXXX, it states that a patient's physical therapy is helping. The next office visit note on XXXX states that the patient has been attending physical therapy but had only attended XX sessions as that is all the XX XX XX would approve. During the office visit notes dated XXXX, it states that XXXX had still denied the XX XX treatment and the patient has still not been able to have any further XX XX due to that denial. On that visit, an MRI was ordered, as well as, XXXX. An MRI was obtained on XXXX. The impression of this study is patient has a XX of the XX XX of the XX XX with XX XX into the XX XX with a XX XX present with prominent reactive XX XX to XX XX involving the XX XX XX as described. Due to all the above and the non-approved treatment that was requested, the patient now requires XX to a XX XX. The patient did all of the requesting conservative care that I had instructed XXXX to do. In fact, XXXX remained XX-XX for XX weeks on XXXX XX after the XX XX procedure that I performed. I even extended XXXX time on crutches a little longer to let the XX XX calm down. However, XXXX continues to have extreme pain and the MRI shows an extensive area of XX XX XX XX despite an extended recovery period. I feel that having already done an XX with a XX procedure and seen the damage from XXXX injury, that this patient will, without doubt, need a XX XX a XX XX XX. There is no medical indication for any continued denial from XX XX regarding approving XXXX next surgery. XXXX injury clearly resulted in a XX of XXXX knee and all other options have already been exhausted. By further denying XXXX next surgery, XX XX is, in essence, just XX this man by forcing XXXX to continue to XX on a XX XX."*

On XXXX completed the reconsideration. The denial for the XX XX XX versus XX XX XX as an inpatient (unspecified number of days) for symptoms related to XX posttraumatic XX of the XX XX was upheld. Rationale: *"Understanding the date of injury, noting that the*

injury resulted in a XX XX requiring XX XX and that the XX XX had been completed when considering the specific XX identified in the Official Disability Guidelines relative to XX XX, the standards have not been met. Noted that there has been concern akin to include exercise therapy, it is not appropriate that XX injections have been administered. There are some XX limitations as a case is required for ambulation, the injured employee is over XXXX -year old, however, it is not clear what the XX XX XX XX XX to. There is a near full range of motion, selection is identified as XX XX. Furthermore, XX XX are not presented, and there is a lack of a calculation of the severity of the XX XX XX. Understanding that several of the criteria outlined in the ODG for this type of surgery have been met, not all of the requirements are objectified. Therefore, there is insufficient clinical data presented to support this request."

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

Prior to surgery, XXXX focused solely on the XX XX as the source of symptoms. This is medically reasonable, as a XX XX XX could have been produced as a result of the XX mechanism of injury (MOI). XXXX documented two diagnoses preoperatively: "XX pain of the XX XX," and "XX XX of the XX XX of XX XX." XXXX did not provide a diagnosis, or even mention, traumatic XX XX XX XX/XX as being the source of symptoms or having any relationship to the XX-XX claim. However, XXXX did identify XX XX XX (due to XX XX XX XX due to XX XX) on XXXX exam. XXXX did not document any loss of range of motion (ROM). XXXX did not document any XX or XX abnormality. XXXX did not diagnose XX, XX XX XX, XX XX, or XX XX of the XX XX XX prior to surgery. XXXX did not recommend a XX XX XX "XX" XX XX. XXXX did not identify any objective MRI evidence of trauma to the XX XX XX—in fact, XXXX stated, "XXXX doesn't have any significant XX XX XX..." A XX XX is a XX improbable source of a substantial acute injury to the XX XX XX XX, particularly without associated XX XX XX. In an individual XX in the XX decade of life, the XX most probable diagnosis is XX (not traumatic) XX/XX. There is no indication in the documentation herewith that XXXX requested, specifically, a XX XX procedure on the XX XX XX as part of the routine preauthorization process.

At the time of surgery on XXXX, XXXX noted "XX on the XX XX XX," but XXXX did not discuss or otherwise specify any criteria for determining whether the XX was XX or XX. The operative note is sparse in detail. A XX XX was listed as the primary procedure, paramount to the XX XX XX, despite no preoperative indications or rationale discussed, described, entertained, or preauthorized (authorization status unknown from the records herewith, but there is no indication that XXXX was considering this procedure preoperatively). A XX XX uses a XX or XX to XX through the XX XX and XX/XX into the underlying XX XX, causing bleeding and XX of XX XX into the XX, as described in the

operative report.

Postoperatively, XXXX and PT noted worsening extension of the XX XX (worse than before surgery, eventually XX XX then XX XX of extension). Even after the XXXX incident just prior to the XXXX follow up, XXXX noted the claimant was "doing better and pain is reducing." On XXXX, about XX weeks status-post surgery, PT noted the claimant, "Wants to take it easy because XXXX will be on a XXXX." On XXXX, PT noted appropriate progress with XX XX-XX degrees. On XXXX, PT produced a Discharge Summary that stated, "Patient is being discharged secondary to prolonged XX XX XX XX/XX XX to XX."

On XXXX, XXXX noted the claimant was "still having trouble gaining full extension," implicating difficulty in getting PT approval.

On XXXX, XXXX noted use of XX and XX, sharp XX XX pain, XX, and XX. On exam, the claimant XX XX.

On **XXXX**, a postoperative XX XX MRI identified a persistent, even XX XX XX XX than before surgery, now with a XX XX in the XX XX. Also, unlike the preoperative MRI, there was substantial XX XX XX XX XX XX XX.

On **XXXX**, XXXX produced a Letter of Medical Necessity, wherein XXXX describes some of the treatment history and the findings on the postoperative MRI stating, "Due to all the above and the non-approved treatment that was requested, **XXXX** is now requiring XX to a XX XX." XXXX goes on to say that the "extensive area of XX XX XX XX" remains (on the postoperative MRI), stating that having performed a [presumably nonauthorized] "drilling procedure and seen the damage from XXXX injury, a XX versus XX XX XX was indicated. XXXX stated that, "XXXX injury clearly resulted in a deterioration of XXXX XX and all other options have already been exhausted." XXXX opined that XX XX was "just XX this man by forcing XXXX to continue to XX on a XX XX."

XXXX does not discuss specific ODG criteria for XX or XX XX XX; instead, these appear to be XXXX main points:

- "due to all the above" referencing postoperative MRI and oral medications, as well as "non-approved treatment" referencing denials of PT;
- Patient did all of the conservative care "that I had instructed XXXX to do;"
- Damage from the injury;
- No medical indication for "continued denial from XX XX regarding approving the next surgery;"
- Injury resulted in "XX of XXXX XX;" and
- "all other options have already been exhausted."

None of the above commentary from XXXX *directly* addresses the specific ODG criteria for XX or XX XX XX.

More objective evidence exists to support the conclusion that the XX/XX XX damaged the XX more so than the XX XX-XX XX. The XX/XX XX was not an original indication for surgery. The claimant's continued XX complaints are due to the XX/XX XX. There is no indication that the claimant had any XX symptoms prior to the surgery, despite having a clinical sign of XX XX (XX XX). The claimant presented with painful XX XX and XX, not XX symptoms. There is no documentation that the claimant had any treatment for XX prior to the surgery.

The postoperative MRI shows an unresolved XX XX XX. This is difficult to rationalize. Only two medically reasonable conclusion can be derived. One: XXXX did not effectively perform the original XX XX XX. This would result in XX XX XX XX. The correct procedure would be a XX XX XX and repeat XX XX XX. This would be part of the XX-XX claim. Two: The claimant sustained a new injury with a new/recurrent XX XX XX. This would not be part of the XX-XX claim. In either scenario, "conversion" to a XX or XX XX XX is not the medically appropriate solution.

Apart from causality, considering the large, displaced XX XX XX, the request for a "XX" to a XX XX XX is not medically indicated. The claimant essentially has just begun the first phase of conservative care for XX (XX XX) XX XX. ODG cites indications for conservative and surgical measures to treat XX. The previous reviewers have cited a lack of conservative management, which appears accurate. Even *if assuming* that the XX of XX XX XX was related to the XX-XX claim, conservative treatment has not even begun, much less exhausted. It is not apparent in the records from XXXX that routine XX XX of XX and XX have been performed, specifically to treat XX (XX are unlikely to be effective vis-à-vis the large, XX XX XX XX seen on postoperative MRI; failure of XX to improve the claimant's symptoms should not be misconstrued as evidence of failure to treat XX). One previous reviewer commented on the lack of BMI data, which is not an issue in this case. The patient's XX is not an issue in this case.

ODG cites evidence of XX, either via x-ray or arthroscopic observation. XXXX documented a XX XX XX by XX XX XX of XX XX and XX XX (but did not describe any findings that can reasonably related to XX-XX trauma). Based on medical necessity alone, this finding meets one of the ODG criterium for a XX XX XX, but not a XX XX XX. The request for "XX XX XX XX XX" is a request for two different procedures. The request for a "XX" or XX XX arthroplasty is clearly not indicated, based on the lack of radiographic or arthroscopic evidence of substantial XX XX (mere XX XX) or XX XX XX

disease. Furthermore, XXXX has not documented substantial XX or XX XX symptoms.

Medically Necessary

X Not Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Stoller, D: *Magnetic Resonance Imaging in Orthopaedics & Sports Medicine*, 3rd ed., 2007
Guides to the Evaluation of Permanent Impairment, 4th ed., AMA
ODG: online version.

ODG Integrated Treatment/ Disability Duration Guidelines

Knee and Leg

Note: The Treatment Planning section is not designed to be a rule, and therefore should not be used as a basis for Utilization Review. The Treatment Planning section outlines the most common pathways to recovery, but there is no single approach that is right for every patient, and these protocols do not mention every treatment that may be recommended. See the [XX](#) for complete lists of the various options that may be available, along with links to the medical evidence. The Procedure Summaries are the most important section of ODG Treatment, and that section, not the Treatment Planning section, should be used as a basis for Utilization Review.

Initial Diagnosis

XX

Initial Evaluation

First visit: with Primary Care Physician MD/DO (100%)

1. Check for serious underlying conditions often indicated by deformity or bone crepitation (fractures), displaced patella, tibia or fibula (dislocation), severe pain with motion, infection, additional pain in the back or hip, excessive swelling, nontender mass (possibly indicating tumor), or neurovascular symptoms such as pale, cold skin, painless swelling, and/or paralysis.
2. Determine the incident or incidents that caused the complaint, especially torsion, fixed foot "pop," external lateral force, or forward force with abrupt halt in gait.
3. Determine whether the problem is acute, sub-acute, chronic, or of insidious onset.
4. Determine the severity and specific anatomic location of the pain.
5. Describe location and severity of pain.

6. Assess the ability of the patient to lift and carry weight, from no to full lifting ability.
7. Assess the ability to climb stairs and hills, and walk on uneven ground.
8. Determine any present medication.
9. Determine any previous medical history, history of systemic disease, or history of previous knee injury, previous knee surgery, discomfort or related disability.
10. Investigate non-industrial reasons that commonly exacerbate knee complaints; i.e., recreational sports or other exercise that aggravates the knee, degenerative disorders, and past acute injury.
11. Compare clinical exam findings of injured knee to opposite knee.

Presumptive Diagnosis

Observe the patient's walk and stance for abnormalities, including swelling, deformity, discoloration, inability to extend and difficulty walking.

Examine the knee in an extended position for tenderness and range of motion.

Check for ligament stability while applying pressure with the joint slightly flexed.

Pull the tibia forward to examine the knee at 30 degrees ([Lachman test](#)). Problems with both flexion and extension at once could indicate the need for surgery.

Aspiration can be used on initial atraumatic effusions, but only if there is no sign of cellulitis/infection of the skin.

Anterior knee pain, popping and clicking, and possible cartilage loss (shown through MRI), are indicators of Patellofemoral Syndrome.

Other anterior knee pains, along with tenderness over the patellar tendon, could be signs of patellar tendinitis.

Swelling over the tibial tubercle could indicate Osgood-Schlatter disease, a congenital condition (common in adolescents – not work related).

Prepatellar bursitis and contusion/periostitis could be caused by direct force, prepatellar bursitis by repetitive friction force.

Unexplained knee pain, semi-locking, catching and swelling could be patellofemoral instability, which is often mistaken for a ligament injury. Patellofemoral instability is successfully treated with physical therapy.

Neurologic condition should be assessed, especially for evidence of lumbar disc disease with possible radiation to the knee.

Immediate referral is recommended for patients with neurologic symptoms, infections, tumor, or deformity.

Initial Therapy

The first step is to reduce pain and make the patient feel comfortable, usually with nonprescription analgesics or prescribed pharmaceuticals if necessary. At-home exercises such as bicycling and straight leg lifting or other retraining and weight-bearing activities may aid in rehabilitation, although a physical therapist may be necessary

depending on patient motivation and degree of pain. Exercise and movement have been shown to be more beneficial than total rest, but care must be taken not to overload the knee during weight bearing exercises.

Imaging

If a fracture is considered, patients should have radiographs if the Ottawa criteria are met. Among the 5 decision rules for deciding when to use plain films in knee fractures, the Ottawa knee rules (injury due to trauma and age >XX years, tenderness at the head of the fibula or the patella, inability to bear weight for 4 steps, or inability to flex the knee to 90 degrees) have the strongest supporting evidence. Diagnostic performance of MR imaging is recommended for the menisci and cruciate ligaments of the knee.

Surgery

Immediate emergency surgery is usually unnecessary with knee injuries unless there is a need to drain acute effusions. Otherwise, most knee problems are greatly improved with physical methods alone. Only when exercise programs are unable to increase strength and range of motion in the knee after more than a month, should surgery be considered, and even then, it may not be necessary. Surgery may be considered in the following cases:

Anterior Cruciate Ligament (ACL) Tears: The decision of whether to surgically repair an ACL tear should take into account the patient's work and life needs. For those whose activities do not include active use or load of the knee, surgery may be unnecessary. The rehabilitation process following surgery involves six months of very intense therapy so non-surgical recovery should be allowed to occur as much as possible before any surgery takes place. Confirmation of a complete tear in the ligament through MRI findings, clear signs of instability confirmed through the [Lachman](#) and [pivot test](#), and a history of frequent falls or giving way, are consistent with this condition. See [ODG Indications for Surgery](#) -- Anterior cruciate ligament (ACL) repair.

ODG Return-To-Work Pathways

Severe (tear), Grade III/IV, ACL repair, sedentary/modified work: 35 days

Severe (tear), ACL repair, manual/standing work: 180 days

(See ODG Capabilities & Activity Modifications for Restricted Work under "Work" in Procedure Summary)

Collateral Ligament Tears: Surgery is usually unnecessary; healing often occurs with rehabilitative exercises alone.

Meniscus Tears: Patients with meniscus tears that are not severely limiting or progressive may not need surgical attention. 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 may not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis.

ODG Return-To-Work Pathways

Without surgery, clerical/modified work: 0-2 days

Without surgery, manual/standing work: 21 days

With arthroscopy, clerical/modified work: 14 days

With arthroscopy, manual/standing work: 42 days

With arthrotomy, clerical/modified work: 28 days

With arthrotomy, manual/standing work: 56 days

With arthrotomy, heavy manual/standing work: 84 days

Osteochondral Defects: Studies are still being done to test the effectiveness of osteochondral autograft transplant system (OATS) procedures for osteochondral defects. Patients under XX years old with active lifestyles may benefit from OATS and the procedure may delay the development of osteoarthritis.

Patellofemoral Syndrome (PFS): While commonly treated with arthroscopic patellar shaving,

this procedure is not proven in terms of long-term improvement. In cases of severe patellar degeneration, surgery is usually not helpful. For patients with rheumatoid conditions, patellectomy and patellar replacements are sometimes performed on active patients. Other possible surgeries for PFS are lateral arthroscopic release and surgical realignment of the extensor mechanism.

ODG Return-To-Work Pathways

Arthroscopy, clerical/modified work: 7-10 days

Arthroscopy, manual work: 28 days

Arthroscopy, debridement of cartilage, clerical/modified work: 7-14 days

Arthroscopy, debridement of cartilage, manual work: 30 days

Arthrotomy, clerical/modified work: 21 days

Arthrotomy, manual work: 49 days

Arthritis: Therapeutic exercises are beneficial for knee osteoarthritis. XX is an effective agent for relief of knee pain. Although safer, it is less effective than NSAIDs. For safety reasons, XX should be the first line treatment, with NSAIDs reserved for those who do

not respond. XX may provide effective symptomatic relief for patients with osteoarthritis of the knee. In addition, XX has shown promising results in modifying the progression of arthritis over a 3-year period. XX has a tolerability profile similar to that of placebo and is better tolerated than XX or XX. Intra-articular injection of XX XX (e.g., XX) can decrease symptoms of XX of the knee. The short-term benefit of intra-articular (IA) XX in treatment of knee XX is well established, and few side effects have been reported. Longer-term benefits have not been confirmed. Total knee arthroplasties are well accepted as reliable and suitable surgical procedures to return patients to function.

ODG Return-To-Work Pathways

Medical treatment: 0 days

Visco injection, knee: 7 days

Partial arthroplasty, knee: 28 days

Arthroplasty, knee, clerical/modified work: 42 days

Arthroplasty, manual work: 84 days

Obesity comorbidity (BMI \geq 30), multiply by: 1.31

¹ **Definition of Sprain/Strain Severity Grade:** In general, a **Grade I** or mild sprain/strain is caused by overstretching or slight tearing of the ligament/muscle/tendon with no instability, and a person with a mild sprain usually experiences minimal pain, swelling, and little or no loss of functional ability. Although the injured muscle is tender and painful, it has normal strength. A **Grade II** sprain/strain is caused by incomplete tearing of the ligament/muscle/tendon and is characterized by bruising, moderate pain, and swelling, and a **Grade III** sprain/strain means complete tear or rupture of a ligament/muscle/tendon. A sprain is a stretch and/or tear of a ligament (a band of fibrous tissue that connects two or more bones at a joint). A strain is an injury to either a muscle or a tendon (fibrous cords of tissue that connect muscle to bone). ([Hannafin-NIH, 2004](#))

ODG Indications for Surgery™ -- 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

4. Imaging Clinical Findings: (Not required for locked/blocked knee.) Meniscal tear on MRI (order MRI only after above criteria are met). ([Washington, 2003b](#))

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