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Notice of Independent Review Decision

R*eview Outcome*

Description of the service or services in dispute:

Right knee arthroscopy with partial medial and lateral meniscectomy; and debridement chondroplasty.
29880 – Arthroscopy of knee surgical, with meniscectomy medial and lateral
29877 – Arthroscopy of knee, surgical, with shaving of articular cartilage
A4550 – Surgical trays
G9009 – Coordinated care fee, risk adjusted maintenance, level 3

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)

XX is a XX who was diagnosed with peripheral tear of lateral meniscus, current injury, right knee, initial encounter (S83.261A), other tear of medial meniscus, current injury, right knee, initial encounter (S83.241A), unilateral primary osteoarthritis, right knee (M17.11), contusion of right knee, initial encounter (S80.01XA). On XX, a XX in front of XX, and XX twisted XX knee and XX the ground.

On XX, XX was evaluated by XX, DO for follow-up regarding knee injury. XX indicated that a XX injury had caused meniscal tear despite the pre-existing arthritis in the knee. Right knee inspection revealed trace effusion with minimal guarding. Mild valgus without pain was noted. There was peripatellar tenderness and medial joint line tenderness. The right knee range of motion showed painful mild crepitus with motion. McMurray's test was positive medially.

Treatment to date included medications XX, XX XXl and XX), home exercise program and physical therapy, which made the symptoms worse. XX injection on the right knee dated XX did not help.

An MRI of the right lower extremity dated XX documented prominent osteoarthritic change most notable to the lateral tibial femoral compartment, prominent tear through the lateral meniscus, tears noted in the medial meniscus as well, patellar tendinosis and sprain or partial tear of the lateral collateral ligament.

Per the peer review dated XX and adverse determination letter dated XX, the request for right knee arthroscopy with partial medial lateral meniscectomy and debridement chondroplasty was not certified. It was determined that the health care services requested did not meet established standards of medical necessity. Rationale: "The ODG does not recommend meniscectomy in the setting of osteoarthritis in the

absence of solid mechanical meniscal findings or in XX patients with degenerative tears who are more appropriately treated with physical therapy. The ODG only recommends chondroplasty for large unstable chondral defects on MRI. The provided documentation indicates diagnoses of medial and lateral meniscus tears in the setting of prominent osteoarthritlc change of the patellofemoral and lateral compartments. The clinician notes that the meniscus tears are likely degenerative in nature. There is persistent right knee pain despite a XX injection, but there is no inclication that physical therapy has been formed. There is no indication of a large unstable chondral defect on MRI to support the chondroplasty. During tl1e peer-to-peer process, the clinician noted that the claimant has done a home exercise program, but the clinician was unsure if there has been formal physical therapy. The clinician acknowledged the underlying arthritis but noted that the surgery is to address the meniscus tears. They were agreeable that the cbondroplasty is not necessary. There is a lack of motion following the injury. The clinician was unable to perform a McMurray's test due to guarding The clinician noted that while there is arthritis, the arthritis is not severe enough to warrant total knee arthroplasty. Based on the provided information of a lack of mechanical symptoms and a lack of formal physical therapy, the request is not supported. Therefore, the request for right knee arthroscopy with partial medial lateral meniscectomy and debridement chondroplasty is not medically necessary."

Per a peer review dated XX and an adverse determination reconsideration letter dated XX, the request upheld the original non-certification. Rationale: "There was a previous adverse determination dated XX whereby the requests for right knee arthroscopy with partial medial-lateral meniscectomy and debridement chondroplasty were non-certified. ODG Knee and Leg (updated XX) Online version Meniscectomy. Recommended as indicated below for symptomatic meniscal tears in XX patients, primarily for traumatic tears. Not recommended for osteoarthritis (OA) in the absence of solid mechanical meniscal findings or in XX patients with degenerative tears who are more appropriately treated with physical therapy/exercise."

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

Based on the documentation provided, the treating clinician indicated that the primary pain complaint was likely due to the information from the underlying osteoarthritis rather than meniscus tears and notes that the meniscus tears are likely degenerative in nature. This resulted in the initial corticosteroid injection and a recommendation for resuming formal physical therapy. Authorization was subsequently received and an injection was performed on XX. An XX indicates no benefit from the injection. The provider now notes locking and popping of the knee as well as pain and recommends proceeding with partial meniscectomy. Radiographs revealed lateral joint space narrowing and osteophyte formation with slight valgus deformity. The initial peer review indicates that a peer to peer conversation was completed, but the provider was unsure if any formal physical therapy had been performed. Based on the information available, I would agree with the initial peer review that the chondroplasty would not be supported and as the provider was unable to offer any information regarding formal physical therapy during the peer to peer conversation, there would be no need to proceed with partial meniscectomy in the setting of significant degenerative change. The second review indicated noncertification was necessary as there is no documentation of solid mechanical complaints and the chondroplasty was not supported. In this case, I would recommend partially overturning the previous decisions. While chondroplasty would clearly not be indicated for management of the osteoarthritis given the absence of an isolated chondral defect, proceeding with partial meniscectomy would be supported. There is a documented failure of conservative modalities to include a home exercise program, oral XX, and an intra-articular XX injection. Progress notes do indicate subjective complaints of locking consistent with meniscal pathology, and the progress notes indicate no formal physical therapy was attended, although the peer to peer information does not appear to support this. However, given the duration of symptoms and documented failure of conservative treatment, and given the subjective mechanical complaints, positive objective examination findings, pathology on imaging, and reported failure of adequate conservative modalities, proceeding with partial meniscectomy would be reasonable.

CPT code 29880, A4550 and G9009 are supported as medically necessary. CPT codes 29877 would not be supported as medically necessary.

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
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐
- ☐

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Case Number:XX Date of Notice: 07/19/18

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

☐ 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)

☐ 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.