MEDICAL CONTESTED CASE HEARING NO. 11103
M6-10-27568-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUE

A contested case hearing was held on November 23, 2010 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization that Claimant is not entitled to right knee medial meniscectomy and chondroplasty for the compensable injury of _____?

The evidence presented strongly indicated that the reference to chondroplasty in the IRO decision was a typographical error, as it was not part of the original request and that procedure was not further addressed in the IRO decision. Therefore, the record was reopened. On January 14, 2011, the parties appeared telephonically and agreed that the issue as certified was incorrect and should be reformed as follows:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization that Claimant is not entitled to right knee medial meniscectomy for the compensable injury of _____?

An order reforming the issue was mailed to the parties requesting that they respond if they disagreed with the reformation of the issue. Parties did not object and the record was closed on January 20, 2011.

PARTIES PRESENT

Petitioner/doctor appeared telephonically without representation. Claimant appeared and was assisted by DB, ombudsman. Respondent/Carrier appeared and was represented by ST, attorney.

BACKGROUND INFORMATION

Claimant suffered an injury to her right knee in the course and scope of her employment on _____. Two utilization reviews were conducted. Both utilization reviews denied the requests. Dr. N appealed the Carrier's decision to an Independent Review Organization (IRO). The IRO upheld the Carrier's denial noting: lack of documentation of a recent MRI; evidence of failure of recent PT (notes of recent therapy not submitted); and/or injections such as viscous supplementation. Based on these concerns, the IRO found that surgical intervention is not reasonably required as per the guidelines.

Dr. N appealed the decision of the IRO to a Medical Contested Case Hearing. Although the Claimant underwent injections to the right knee which failed to relieve her symptoms, the injections occurred after the IRO rendered its decision and will not be considered.

DISCUSSION

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines in making decisions about the care of individual patients. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. (Texas Labor Code Section 413.011(e).) Medical services consistent with the medical policies and fee guidelines adopted by the Commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is considered a party to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence. (Division Rule 133.308 (t).)

With regard to knee medial meniscectomy, the ODG provides as follows:

> Recommended as indicated below for symptomatic meniscal tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings. (Kirkley, 2008) Meniscectomy is a surgical procedure associated with a high risk of knee osteoarthritis (OA). One study concludes that the long-term outcome of meniscal injury and surgery appears to be determined largely by the type of meniscal tear, and that a partial meniscectomy may have better long-term results than a subtotal meniscectomy for a degenerative tear. (Englund, 2001) Another study concludes that partial meniscectomy may allow a slightly enhanced recovery rate as well as a potentially improved overall functional outcome including better knee stability in the long term compared with total meniscectomy. (Howell-Cochrane, 2002) The following characteristics were associated with a surgeon's judgment that a patient would likely 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 Lachmann or anterior drawer test. (Solomon, 2004) Our conclusion is that 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 will not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis, and meniscectomy will not improve the OA. Meniscal repair is much more complicated than meniscal excision (meniscectomy). Some surgeons state in an operative report that they performed a meniscal repair when they may really mean a meniscectomy. A meniscus repair is a surgical procedure done to repair the damaged meniscus. This procedure can restore the normal anatomy of the knee, and has a better long-term prognosis when successful. However, the meniscus repair is a more significant surgery, the recovery is longer, and, because of limited blood supply to the meniscus, it is not always possible. A meniscectomy is a procedure to remove the torn portion of the meniscus. This procedure is far more commonly performed than a meniscus repair. Most meniscus tears cannot be treated by a repair. See also Meniscal allograft transplantation. (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 and knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for all patients with knee osteoarthritis. (Siparsky, 2007) Arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical and medical therapy, according to the results of a single-center, RCT reported in the *New England Journal of Medicine*. The study, combined with other evidence, indicates that osteoarthritis of the knee (in the absence of a history and physical examination suggesting meniscal or other findings) is not an indication for arthroscopic surgery and indeed has been associated with inferior outcomes after arthroscopic knee surgery. However, osteoarthritis is not a contraindication to arthroscopic surgery, and arthroscopic surgery remains appropriate in patients with arthritis in specific situations in which osteoarthritis is not believed to be the primary cause of pain. (Kirkley, 2008) Asymptomatic meniscal tears are common in older adults, based on studying MRI scans of the right knee of 991 randomly selected, ambulatory subjects. Incidental meniscal findings on MRI of the knee are common in the general population and increase 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) Arthroscopic meniscal repair results in good clinical and anatomic outcomes. (Pujol, 2008) Whether or not meniscal surgery is performed, meniscal tears in the knee increase the risk of developing osteoarthritis in middle age and elderly patients, and individuals with meniscal tear were 5.7 times more likely to develop knee osteoarthritis. (Englund, 2009)

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):
1. Conservative Care: (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. 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. (Washington, 2003)

To overcome the IRO's decision, Dr. N provided his expert medical testimony. The carrier did not object to Dr. N's testimony and it is therefore, admissible. Dr. N was qualified to give his expert opinion based on his education, training, and experience within the medical field, his review of the pertinent records, and his examination of the patient; his testimony was not irrelevant, conclusory, or speculative; nor was it based on an unreliable foundation.

During his testimony, he explained precisely how the Claimant met the requirements of the ODG for medial meniscectomy of the right knee. Specifically, an MRI dated March 18, 2010 revealed a tear in the posterior horn of the medial meniscus. This report was in existence 3 months prior to the IRO report. Dr. N further explained that the Claimant failed conservative treatment and had sufficient subjective and objective clinical findings on examination to meet the surgical criteria. Dr. N's testimony is further supported by the treating surgeon's surgical request which specifically notes how the Claimant meets the criteria for the requested surgery.

Dr. N's testimony supports the medical necessity of the medial meniscectomy of the right knee and he relies on his physical examinations of the Claimant, the examinations of the treating surgeon and the ODG to support his opinion. The Claimant and provider have shown by a preponderance of evidence-based medical evidence that the requested medial meniscectomy of the right knee is health care reasonably required for the compensable injury.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of (Employer).

   C. Claimant sustained a compensable injury on _____.

   D. The Independent Review Organization determined that the requested services were not reasonable and necessary health care services for the compensable injury of _____.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Medial meniscectomy of the right knee is health care reasonably required for the compensable injury of _____.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is contrary to the decision of the IRO that medial meniscectomy of the right knee is not health care reasonably required for the compensable injury of _____.

DECISION

Claimant is entitled to medial meniscectomy of the right knee for the compensable injury of _____.

ORDER

Respondent/Carrier is liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **ZURICH AMERICAN INSURANCE COMPANY** and the name and address of its registered agent for service of process is:

LEO MALO
12222 MERIT DRIVE, SUITE 700
DALLAS, TEXAS 75251

Signed this 9th day of February, 2011.

Katherine D'Aunno-Buchanan
Hearing Officer