MEDICAL CONTESTED CASE HEARING NO. 15010

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determined that:

Claimant is not entitled to left knee surgery- medial meniscal tear. Claimant/Petitioner did not timely appeal the Independent Review Organization decision in this case.

STATEMENT OF THE CASE

On October 24, 2014, Britt Clark, a Division hearing officer, held a contested case hearing to decide the following disputed issues:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to left knee surgery- medial meniscal tear?
2. Did the Claimant/Petitioner timely appeal the IRO decision?

PARTIES PRESENT

Claimant/Petitioner appeared and was assisted by EJ, ombudsman. Carrier/Respondent appeared and was represented by CL, attorney.

DISCUSSION

Timeliness of Appeal

Rule 133.308(s)(1)(A) states, to wit:

> The written appeal must be filed with the division's Chief Clerk of Proceedings no later than the later of the 20th day after the effective date of this section or 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. Requests that are timely submitted to a division location other than the division's Chief Clerk of Proceedings, such as a local field office of the division, will be considered timely filed and forwarded to the Chief Clerk of Proceedings for processing; however, this may result in a delay in the processing of the request.

In this particular case, the IRO decision was issued and sent to the parties on July 14, 2014. The applicable deadline for the filing of the appeal of the IRO decision in this case was 20 days from the date the IRO decision was sent to the parties. Claimant/Petitioner offered a file-stamped

copy of his written appeal and request to schedule a medical contested case hearing. However, the file stamp showed that the request was filed with the Division on August 14, 2014, which was untimely. Claimant argued that he emailed his request to the Division on August 4, 2014. Based on the evidence presented, the Hearing Officer is unable to confirm that the Division received his request on August 4, 2014 via email. Moreover, email correspondence is not an accepted method to file documentation with the Division. There are no other applicable provisions and/or Division Rules providing for extensions of and/or good cause exceptions to the 20-day deadline for appealing the IRO decisions. Because the Claimant/Petitioner did not comply with the 20-day deadline contained in the applicable Division Rules, the appeal of the IRO decision was untimely.

Medical Necessity

Evidence Based Medicine (EBM)

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. 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. Also, in accordance with Division Rule 133.308(s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties 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."

On the date of this medical contested case hearing, the Official Disability Guidelines provides the following with regard to knee meniscal repair and meniscectomy:

> Recommended as indicated below for symptomatic meniscal tears for younger patients and for traumatic tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings, or in older patients with degenerative tears until after a trial of PT/exercise. (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) 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) AHRQ Comparative Effectiveness Research concluded that arthroscopic lavage for osteoarthritis, with or without debridement, does not improve pain and function for people with OA of the knee. (AHRQ, 2011) The repair of meniscal tears is significantly improved when performed in conjunction with ACL reconstruction. (Wasserstein, 2011) In patients with a nontraumatic degenerative medial meniscal tear and no knee osteoarthritis, arthroscopic partial meniscectomy is no better than sham surgery according to a high quality RCT. While arthroscopic partial meniscectomy is the most common orthopedic procedure performed in the U.S., rigorous evidence of its efficacy is lacking. While the results may argue against the current practice of performing arthroscopic partial meniscectomy in patients with a degenerative meniscal tear, the study did not compare meniscectomy with no treatment, because in the sham surgery group, they inserted an arthroscope and put fluid through the knee. (Sihvonen, 2013)

Physical therapy vs. surgery: In older patients with degenerative tears and symptoms caused by osteoarthritis, PT/exercise may be an appropriate first option and it may be possible to reserve surgery for those who do not benefit from PT alone. A high quality RCT, the Meniscal Tear in Osteoarthritis Research (METEOR) trial, found similar outcomes from PT versus surgery for meniscal tears in older individuals. Researchers at seven major universities and orthopedic surgery centers around the U.S. assigned 351 people with arthritis and meniscus tears to get either surgery or physical therapy, nine sessions on average plus exercises to do at home. After six months, both groups had similar rates of functional improvement, and pain scores were also similar. While 30% of patients assigned to physical therapy wound up having surgery before the six months was up, often because they felt therapy was not helping them, they ended up the same as those who got surgery right away, as well as the rest of the physical therapy

group who stuck with it and avoided having an operation. These results suggest that physical therapy may be an appropriate first option for many patients with osteoarthritis and meniscal tears and that it may be possible to reserve surgery for those who do not benefit from physical therapy alone. (Katz, 2013) Another RCT comparing meniscectomy to strengthening exercises in patients presenting with degenerative medial meniscus tear and no clear evidence of osteoarthritis (Kellgren-Lawrence grade 0-1) found no significant between-group differences in function, pain, or patient satisfaction scores. (Yim, 2013) 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) In this RCT, arthroscopic partial medial meniscectomy followed by supervised exercise was not superior to supervised exercise alone in terms of reduced knee pain, improved knee function and improved quality of life, after non-traumatic degenerative medial meniscal tear in ninety patients, mean age 56 years. (Herrlin, 2007) (Marcus, 2002) (Moseley, 2002) See also Arthroscopic surgery for osteoarthritis.

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, 2003)

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

Claimant/Petitioner sustained a compensable injury on (Date of Injury). Pre-authorization was requested for left knee surgery- medial meniscal tear. The IRO Reviewer upheld the previous denials, and Claimant/Petitioner appealed. Carrier/Respondent argued the opinion of the IRO Reviewer was correct. Claimant/Petitioner testified concerning the mechanism of injury, his course of treatment and his continuing pain and limitations; however, a qualified expert medical opinion with reference to evidence-based medicine was necessary for claimant to meet his burden of proof on this matter and such evidence-based medical evidence was lacking in this case. As such, insufficient evidence-based medical evidence existed to explain that the requested surgery was health care reasonably required for the compensable injury. Therefore, the preponderance of the evidence is not contrary to the decision of the IRO that Claimant/Petitioner is not entitled to left knee surgery- medial meniscus tear.

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

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

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

   C. On (Date of Injury), Claimant was the employee of (Employer), Employer.

   D. On (Date of Injury), Employer provided workers' compensation insurance through The Travelers Indemnity Company of Connecticut, Carrier.

   E. On (Date of Injury), Claimant sustained a compensable injury.

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

3. Claimant/Petitioner's appeal of the IRO decision was not filed within the 20-day deadline contained in Division Rule 133.308(s)(1)(A).

4. Left knee surgery- medial meniscal tear is not health care reasonably required for the compensable injury of (Date of Injury).

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 not contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to left knee surgery- medial meniscal tear.

4. Claimant/Petitioner did not timely appeal the IRO decision in this case.

DECISION

Claimant is not entitled to left knee surgery- medial meniscal tear. Claimant/Petitioner did not timely appeal the IRO decision in this case.

ORDER

Carrier/Respondent is not liable for the benefits at issue in this hearing. Claimant/Petitioner remains entitled to medical benefits for the compensable injury in accordance with § 408.021.

The true corporate name of the insurance carrier is **THE TRAVELERS INDEMNITY CO. OF AMERICA**, and the name and address of its registered agent for service of process is

CORPORATION SERVICE CO.
d/b/a CSC- LAWYERS INCORPORATING SERVICE CO.
211 EAST 7th STREET, STE. 620
AUSTIN, TX 78701-3218

Signed this 30th day of October, 2014.

BRITT CLARK
Hearing Officer