SOAH DOCKET NO. 453-05-3057.M2
TWCC MR NO. M2-05-0204-01

___,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
DALLAS FIRE INSURANCE COMPANY,	§	
Respondent	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

Mr. ___ (Petitioner), an injured claimant, has challenged the decision of an Independent Review Organization (IRO) acting on behalf of the Texas Workers' Compensation Commission (Commission)[1] in a dispute regarding preauthorization for a left knee arthroscopy with meniscectomy (medial or lateral).[2] The IRO found that the proposed procedure was not medically necessary and that Dallas Fire Insurance Company (Respondent) had properly denied preauthorization for it. Petitioner had the burden of proof in this proceeding but failed to establish that the proposed treatment is medically necessary and should be preauthorized; therefore, the Administrative Law Judge (ALJ) denies preauthorization.

I. JURISDICTION AND HEARING

There were no challenges to notice or jurisdiction; therefore, those matters are set forth in the findings of fact and conclusions of law without further discussion here. ALJ Renee M. Rusch conducted a hearing in this matter on November 1, 2005, at the hearings facility of the State Office of Administrative Hearings (SOAH) in the William P. Clements Building, 300 W. 15th Street, Austin, Texas. Petitioner represented himself and appeared by telephone, with assistance from

[1] Effective September 1, 2005, the functions of the Commission have been transferred to the newly created Division of Workers' Compensation at the Texas Department of Insurance.

[2] The knee joint consists of three bones: the patella (knee cap), femur (thigh bone), and tibia (shin bone). The knee joint contains two joints: the tibiofemoral joint (between the tibia and the femur) and the patellofemoral joint (between the patella and the femur). The meniscus is a crescent-shaped disc of fibrocartilage between the joints formed by the femur and the tibia. A meniscectomy involves excision (removal) of the meniscus or a torn piece of the meniscus. *See Dorland's Illustrated Medical Dictionary* (28th Ed., 1994) at 1012-13, 1711.

Commission Ombudsman Anthony Walker. Respondent was represented by attorney Christine Karcher, who appeared by telephone. Both parties offered multiple medical records into evidence. Petitioner testified on his own behalf, and Mitchell Books, M.D., a board-certified orthopedic surgeon, testified as an expert witness on behalf of Respondent. After presentation of evidence and argument, the hearing was adjourned that same day.

II. STATEMENT OF THE CASE

Petitioner, who is in his early 40s, has experienced knee problems since he was in high school. In 1981 Petitioner underwent surgery to remove calcium deposits from the patellar tendon in his left knee. (Resp. Ex. A at 9 and 245.) In 2002, Petitioner suffered a work-related injury to his right knee for which he underwent surgery in November 2002. In February 2003, Petitioner returned to work (as a construction superintendent) on crutches while he was still recovering from his right knee surgery. On ___, while Petitioner was walking on a job site, he felt both knees "give out" and his left knee "pop." Petitioner fell halfway but was able to catch himself on a piece of equipment. Treatment for the left knee injury resulting from that incident is the subject of this proceeding.

An MRI taken on April 30, 2003, suggested Petitioner might have a patellar ligament or patellar tendon tear.[3] (Resp. Ex. A at 180, 184, and 247.) Petitioner experienced pain, weakness, and grinding in his left knee. The symptoms did not respond to conservative treatment. Therefore, on October 1, 2003, surgeon Luis H. Urrea, II, M.D., performed surgery on Petitioner's left knee. The procedures performed included diagnostic left knee arthroscopy, open exploration of the left patella, debridement of the tendon, and drilling of the patella to allow for a healing bleeding

[3] A ligament is a tough, fibrous band of tissue that connects bones. A tendon is an inelastic, fibrous band that connects muscle to bone. The patellar tendon extends down from the quadriceps muscle in the thigh to incorporate the patella (knee cap) and attach it to the tibia (shinbone), providing extension at the knee joint. The patellar tendon is also called the patellar ligament because it connects the patella to the tibia. Petitioner's medical records contain both terms, patellar tendon and patellar ligament. The report of the April 30, 2003, MRI refers to a suspected patellar ligament tear; the report of Petitioner's October 1, 2003, surgery states one of the purposes of the surgery was to rule out a patellar tendon tear; Petitioner's current treating doctor, Eduardo Hazarian, M.D., recorded in Petitioner's medical history that the April 30, 2003, MRI was interpreted as showing a rupture of the patellar tendon. (Resp. Ex. A at 180, 184, and 247.)

environment. During that surgery, Dr. Urrea found some longstanding calcium deposits (these calcium deposits apparently caused some fraying of the patellar tendon), but Dr. Urrea found no evidence of a patellar tendon tear, meniscal tear, or acute trauma to the knee joint. Petitioner testified he was told a fluid sample was taken from his knee during the surgery, a biopsy performed, and a pathology report prepared that indicated a diagnosis of gouty arthritis.[4]

Following the left knee surgery, Petitioner underwent physical therapy from November 19, 2003 through January 14, 2004. (Resp. Ex. A at 205-231.) The evidence is contradictory as to whether the surgery brought Petitioner any relief. On November 28, 2003, he reported he felt 50 percent improvement.[5] (Resp .Ex. A at 211.) However, he also told doctors and testified that the surgery did not relieve his symptoms. (*See, e.g.*, Resp. Ex. A at 245.)

Petitioner complains of continuing pain, weakness, and grinding in his left knee. He wears a long leg brace, walks with a limp, and reports that he can only walk short distances without a cane or crutches. The doctors who requested preauthorization for the proposed procedure, surgeon Alvaro Hernandez, M.D., and Petitioner's current treating doctor, Eduardo Hazarian, M.D., have diagnosed his current condition as patellofemoral joint arthrosis and assume he has a torn meniscus. (Pet. Ex. A at 7, 11.) The purpose of the proposed procedure would be to take a "second look" inside Petitioner's left knee joint in hopes of ascertaining whether Petitioner may be a candidate for additional surgery.

Respondent denied preauthorization, contending that the procedure is not medically necessary. A peer reviewer and a IRO reviewer who is a board-certified orthopedic surgeon concurred. (Resp. Ex. A. At 22-26.) The IRO reviewer supported denial of the proposed treatment on two bases:

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[4] Petitioner's medical history reflects a history of gout in his feet and, more recently, in his knees. Although Petitioner was treated for gout circa 1990, he testified that he has not received any treatment for gout since 2002, *i.e,* before the compensable injury involved in this dispute.

[5] As of November 28, 2003, Petitioner's diagnosis was knee sprain, leg calcium deposits in tendon/bursa, and gout. (Resp. Ex. A at 211.) As of January 5, 2004, his diagnosis was the same, except that his gout was described as "gout with tophi." (Resp. Ex. A at 228.)

> There is no evidence . . . of a tear of the meniscus nor is there a recent MRI. . . . There is a lot of evidence of patellofemoral disease but . . . no evidence that the arthroscopy will change that in any significant way. Resp. Ex. A at 9.)

Petitioner underwent another MRI, on November 4, 2004, which reflected erosion of Petitioner's left patella but no tendon or meniscal tear. (Pet. Ex. 1 at 17.)

III. REASONS FOR DECISION

A. ALJ's Analysis

Respondent's expert witness, Dr. Brooks, a board-certified orthopedic surgeon, testified with considerable conviction that, in his opinion, the proposed procedure is not medically necessary. Petitioner, who had the burden of proof, presented no testimony from medical professionals to challenge Dr. Brooks's opinion or his interpretation of Petitioner's medical records. According to Dr. Brooks, when Petitioner was examined by Brian J. August, M.D., on April 22, 2003, only 18 days after his injury, Dr. August's objective findings were consistent with the mechanism of Petitioner's injury and suggested Petitioner had suffered a mild trauma that resulted in a minor sprain of the patellar tendon.[6] Dr. Brooks characterized Dr. August's findings as consistent with the mechanism of injury, *i.e.*, as Petitioner was falling, he caught himself half way by quickly contracting his quadraceps and patellar tendon to stabilize himself.

Because conservative treatment did not relieve Petitioner's symptoms, and because the April 30, 2003, MRI suggested Petitioner might have a patellar ligament tear, Dr. Brooks believes it was reasonable to perform the October 1, 2003, surgery.

According to Dr. Brooks, however, the symptoms Petitioner has reported to the doctors who have examined and treated him since the October 1, 2003, surgery do not correlate with the doctors' objective findings on examination. *See, e.g.*, Resp. Ex. A at 211, 218, 227, and 244-248. Moreover,

[6] Dr. August's initial diagnosis was internal derangement of the left knee. (Resp. Ex. A at 176-77.)

Petitioner's medical records reflect that he put forth submaximal effort on a Functional Capacity Evaluation (FCE) and may have symptom magnification. During an examination on December 1, 2003, the physical therapist noted, "On exam, he has minimal signs which do not correlate with the symptoms, possibly there is some magnification." (Resp. Ex. A at 212.) When surgeon Dr. Urrea examined Petitioner on March 22, 2004, he noted:

> If he is distracted and I am [palpating his left knee] he has no pain but once he starts focusing on this area it becomes much more painful. . . . He consistently gave submaximal effort during [an FCE on March 15, 2004]. (Resp. Ex. A at 238.)

Dr. Brooks found nothing in Petitioner's medical records for the first year following his compensable ___ injury that indicates Petitioner had a meniscal tear or patella (knee cap) injury. The surgeon's report of the October 1, 2003 surgery expressly indicates that Petitioner did *not* have a meniscal tear or evidence of acute trauma to the knee cap. Thus, if Petitioner currently has a meniscal tear, it cannot possibly be related to his ___ injury. Moreover, according to Dr. Brooks, when Petitioner was examined in March 2004, the examination showed his left knee joint to be normal, for example, he appeared to have full extension and near-complete range of motion. (*See* Resp. Ex. A at 238.)

Dr. Brooks opined that the source of Petitioner's subjective complaints may be gouty arthritis, a condition in which crystals are deposited in the joints; when the crystals become inflamed, they cause considerable pain. Large deposits of crystals form a cottage-cheese-like substance called tophi, which can destroy a joint surface. According to Dr. Brooks, the symptoms of gouty arthritis can mimic meniscal tears or other injuries. The definitive test for gouty arthritis would be to analyze fluid from Petitioner's knee; if the diagnosis of gouty arthritis is confirmed, Petitioner's gouty arthritis should be treated with anti-inflammatory medications. Dr. Brooks was incredulous that none of Petitioner's health care providers had either conducted additional tests or treated Petitioner for gouty arthritis, given that Petitioner testified he was told, after his October 1, 2003 left knee

surgery, that he had the condition. Although Dr. Hazarian, in one of his reports, dismissed gouty arthritis as the source of Petitioner's symptoms, none of the medical records contain any explanation for Dr. Hazarian's conclusion. (Pet. Ex. A at 8.)

In the proposed procedure, a surgeon would take a "second look" at the same structures inside Petitioner's left knee that were examined during the surgery on October 1, 2003, and determined to be intact at that time. Given this evidentiary record, the ALJ is not persuaded that a "second look" is medically necessary. Indeed, Respondent established, through the testimony of Dr. Brooks, that the proposed procedure is not medically necessary.

B. Conclusion

For the reasons summarized above, the ALJ finds that, on the record presented in this case, the proposed services have not been shown to be medically necessary. Accordingly, preauthorization for those services should be denied, in accordance with the prior decision of the IRO.

IV. FINDINGS OF FACT

1. Mr. ___ (Petitioner), who is in his early 40s, has experienced knee problems since he was in high school.

2. In 1981, Petitioner underwent surgery to remove calcium deposits from the patellar tendon in his left knee.

3. Petitioner has had gout since about 1990 but he has not been treated for gout since 2002.

4. On ___, Petitioner suffered a compensable injury to his left knee when he felt his knees "give out" and his left knee "pop" as he began to fall. Petitioner caught himself half- way by contracting his quadraceps and patellar tendon to stabilize himself. The resulting compensable injury is the subject of this proceeding.

5. At the time of Petitioner's injury, Dallas Fire Insurance Company (Respondent), was the workers' compensation insurer for Petitioner's employer.

6. On October 1, 2003, Petitioner underwent surgery, consisting of diagnostic left knee arthroscopy, open exploration of the left patella, and debridement of the tendon and drilling of the patella, to address the injury.

7. The surgery revealed that Petitioner did not have a patellar tendon tear, meniscal cartilage tear, or acute trauma to his left knee joint.

8. In connection with his October 1, 2003, surgery, Petitioner was diagnosed with gouty arthritis in his left knee; however, Petitioner has not received treatment for the gouty arthritis.

9. Gouty arthritis is a condition in which crystals are deposited in the joints; when the crystals become inflamed, they cause considerable pain. Large deposits of crystals form a cottage-cheese-like substance called tophi, which can destroy a joint surface. The symptoms of gouty arthritis can mimic meniscal tears or other injuries.

10. A clinical evaluation of Petitioner's left knee on March 22, 2004, showed his left knee joint was normal.

11. Petitioner reports chronic pain, weakness, and grinding in this left knee.

12. Surgeon Alvaro Hernandez, M.D., and Petitioner's current treating doctor, Eduardo Hazarian, M.D., sought preauthorization for a left knee arthroscopy with meniscectomy (medial or lateral) as a tool for taking a "second look" inside Petitioner's left knee to see whether he may be a candidate for additional surgery.

13. In the proposed procedure, a surgeon would take a "second look" at the same structures inside Petitioner's left knee that were examined during the surgery on October 1, 2003, and determined to be intact at that time.

14. The assumption underlying the request for preauthorization for the proposed procedure is that Petitioner has a meniscal tear.

15. Based on Finding No. 7, if Petitioner currently has a meniscal tear, it cannot be related to his compensable ___, injury.

16. When Petitioner's doctors sought preauthorization for the proposed procedure, Respondent denied preauthorization on the grounds that the proposed procedure is not medically necessary.

17. Petitioner made a timely request to the Texas Workers' Compensation Commission ("Commission") for medical dispute resolution with respect to the requested preauthorization.

18. The independent review organization (IRO) to which the Commission referred the dispute issued a decision on November 4, 2004, concluding that the request for preauthorization should be denied because the requested services are not medically necessary. As its basis for decision, the IRO noted that there is no evidence of a mensical tear.

19. The objective findings on clinical examination of Petitioner's left knee are inconsistent with the symptoms he reports.

20. The objective findings on clinical examination of Petitioner's left knee are inconsistent with the requesting doctors' rationale for seeking the proposed procedure.

21. An MRI examination Petitioner underwent on November 4, 2004, does not support the requestor's assumption that he has a mensical tear.

22. The pain in Petitioner's left knee may be caused by gouty arthritis, a condition with which he has been diagnosed but for which he is not currently receiving treatment.

23. The preponderance of the evidence does not establish that Petitioner has a meniscal tear for which the proposed procedure would constitute medically necessary treatment.

24. Petitioner timely requested a hearing with the State Office of Administrative Hearings ("SOAH"), seeking review and reversal of the IRO decision regarding preauthorization.

25. The Commission sent notice of the scheduling of a hearing in this matter to the parties on December 22, 2004. At the request of the parties, the hearing date was continued three times.

26. A hearing in this matter was convened on November 1, 2005, at the William P. Clements Building, 300 W. 15th St., Austin, Texas, before Renee M. Rusch, an Administrative Law Judge with SOAH. Petitioner and Respondent appeared and presented evidence and argument. The record in the case closed on the same date.

V. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to § 413.031(k) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

2. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and 28 TEX. ADMINISTRATIVE CODE (TAC) § 133.305(g) and §§ 148.001-148.028.

3. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. Petitioner, the party seeking relief, bore the burden of proof in this case, pursuant to 28 TAC § 148.21(h).

5. Based upon the foregoing Findings of Fact, a left knee arthroscopy with meniscectomy (medial or lateral) does not represent health care medically necessary under Section 408.021of the Act.

6. Based upon the foregoing Findings of Fact and Conclusions of Law, the decision of the IRO issued in this matter on November 4, 2004, was correct; preauthorization for a left knee arthroscopy with meniscectomy (medial or lateral) should be denied.

ORDER

IT IS, THEREFORE, ORDERED that the request of Mr. ___ that Dallas Fire Insurance Company be required to preauthorize a left knee arthroscopy with meniscectomy (medial or later) is denied.

SIGNED November 15, 2005.

RENEE M. RUSCH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS