

# P-IRO Inc.

An Independent Review Organization

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**DATE OF REVIEW:** July 27, 2006

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Outpatient right knee micro debridement of the patella tendon

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

Board Certified Orthopedic Surgeon

## **REVIEW OUTCOME**

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Notes, 09/21/06, 09/26/06, 10/03/06,

MRI, 09/29/06

Physical therapy progress notes, 10/20/06, 11/14/06, 11/21/05, 11/28/06, 12/21/06, 01/12/06, 02/08/07, 03/09/07, 04/05/07, 04/12/07, 05/11/07 and 06/13/07

Office note, Dr., 01/06/07

Operative report, 01/30/07

Peer review, 05/18/07 and 05/25/07

Letter of medical necessity, 06/13/07

Note, Primary Care Physician, 06/25/07

Request for an appeal, 06/27/07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female, employed as a school bus driver, who sustained a right knee injury when she stepped on a rock and twisted her knee. Her primary care physician diagnosed a right knee sprain. Treatment included rest, heat, bracing and a non-steroidal anti-inflammatory medication. Pain and swelling continued. An MRI revealed mild thickening along the medial collateral ligament fibers possibly representing a mild MCL sprain without disruption. There was no evidence of meniscal pathology. An orthopedic referral was ordered and the claimant began

physical therapy. Symptoms persisted despite therapy and injections. Subsequently, the claimant underwent right knee arthroscopy on 01/30/07 with anterior compartment plica resection and chondroplasty of the patella. The postoperative diagnosis was chondromalacia patellofemoral joint, grade II–III changes with parapatellar plica, and normal medial and lateral menisci.

Right knee pain persisted postoperatively and apparently, micro debridement of the patella tendon was recommended. The surgical request was non-certified on two separate occasions. Dr. noted in a letter on 06/13/07, the claimant experienced moderate improvement following surgery and continued with anterior knee pain. Diagnostic injections into the patellar tendon had provided complete but temporary relief, which he opined was diagnostic for patellar tendonitis. Therapy was discontinued due to aggravation of symptoms and an appeal to reconsider the surgical request was submitted.

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

The Reviewer agrees with the determination of the insurance carrier in this case. The Reviewer cannot identify a good indication for the requested micro debridement of the patellar tendon in this case.

This claimant has been evaluated by sophisticated imaging studies including an MRI. There have been no findings of operative pathology within the patellar tendon. This is a very unusual treatment request in the management of patellar tendonitis symptoms. Patellar tendonitis has not been confirmed on any imaging studies. Even if there is confirmation of patellar tendonitis, this is a very unusual treatment recommendation which would not be part of the usual armamentarium for patellar tendonitis. Once again, the Reviewer would agree with the previous determination in this case that such a procedure is not medically necessary.

ODG does not specifically address micro debridement of the patella tendon

Orthopedic Sports Medicine, Principles and Practice, DeLee, Drez, Miller  
2<sup>nd</sup> edition, 2003, Chapter 28, page 1793

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)