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## Notice of Independent Review Decision

**DATE OF REVIEW:** 06-27-2007

**IRO CASE #:**

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

Right Knee Arthroscopy, Partial Meniscectomy, Chondroplasty, Microfracture

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

Certified by the American Board of Orthopaedic Surgery  
General Certificate in Orthopaedic Surgery

### **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)

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld/ Overturn
		Prospective	717.9	29881	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Notification of Determination (05-14-2007 and 06-01-2007)  
MRI Report (01-26-2007)  
Physician Evaluation (02-20-2007, 04-20-2007, 05-22-2007)  
Request for Reconsideration Letter (05-26-2007)  
Office Visit Notes (04-03-2007, 04-10-2007, 04-23-2007)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant twisted right ankle on the tracking of a door, caused him to fall on his right knee. The claimant complained of right lateral knee pain – worst on walking, flexing, and rising from chair. MRI right knee on 01-26-2007 showed patella alta – no tear menisci, cruciate and collateral ligaments, no bone marrow edema, fracture or osteonecrosis; small joint effusion. Note partial anterior cruciate ligament tear in 2004. The Physician note of 02-20-2007 reports that the claimant is status post right knee surgery. The examination revealed full motion, negative Apley's McMurray, Lachmann's pivot shift, and posterior drawer. X-ray 4 views were negative. Subsequent visit on 04-20-2007 document tender posterolateral joint line, at about 20 degrees to full extension note a pop, catch, painful sensation.

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

The Reviewer determined that the request for right knee arthroscopy, partial meniscectomy, chondroplasty, microfracture is not medically necessary for this claimant based on the documentation provided for review. The Reviewer noted that the pathology noted during the surgery has not been clearly defined, nor which meniscus was partially removed. The Reviewer wondered why it was necessary for the claimant to wear a "brace" at work, and was there mild/small effusion prior to the fall. In addition, the documentation did not clearly define where the clunk, pop, catch, is/are. Lastly, there was no clear evidence that the claimant had formal physical therapy for this episode, and there was no evidence of bone marrow edema.

**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)