



Specialty Independent Review Organization

**DATE OF REVIEW:** 9/25/2007

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a left knee arthroscopy with meniscectomies and removal of loose bodies.

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

The reviewer is a board certified Medical Doctor who specializes in Orthopedic Surgery who has been practicing for greater than 10 years.

**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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a left knee arthroscopy with meniscectomies and removal of loose bodies.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

These records consist of the following:

9/6/07 TDI notice of IRO assignment; 8/30/07 Letter of recommendation – DC; letter of denial-8/6/07, 7/25/07 by MD; of Montana acting as a consultant denying treatment as prognosis was guarded; 7/27/07 letter of medical necessity resubmission for arthroscopy, medial and lateral partial meniscectomies, resection of loose bodies, and possible chondroplasty.

Records from Doctor/Facility: Dr. office notes-8/24/07 documentation of loss of ROM -10 to 90 degrees, joint line tenderness, positive patellar grind, positive McMurray's antalgic gait, 7/20/07 ROM -10 to 105 degrees, 7/11/07 ROM -10 to 105 degrees 6/22/07; Center – MRI report 6/27/07; LPC-office notes 7/13/07.

Records from Carrier: Dr. – office notes 7/20/07, 7/11/07 documentation of locking and catching, 6/22/07 Center – MRI report 6/27/07, Letter of Denial- 8/6/07, 7/25/07.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient was injured when falling at work. She was managed in PT by her chiropractor for 6 visits prior to being referred for orthopedic assessment. She reports knee pain, instability and joint line tenderness. The left knee examination of 6/22/07 was significant for medial and lateral joint line tenderness, positive Apley's, McMurray's and patellar grinding testing. Anterior drawer testing was negative. MRI revealed tricompartmental DJD with valgus deformity, lateral patellar subluxation, probable chronic ACL tear, probable chronic degenerative loss of anterior horn and body of the lateral meniscus and loose bodies. The orthopedic exam reveals deteriorating ROM.

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

According to the ODG, the indications for meniscal surgery include the following:

- 1. Conservative Care:** (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. PLUS
- 2. Subjective Clinical Findings:** Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS
- 3. Objective Clinical Findings:** 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.

The clinical signs and symptoms as documented by the treating doctor are consistent with an acute traumatic meniscal injury superimposed upon premorbid degenerative changes. The MRI verifies tricompartmental DJD with valgus deformity, lateral patellar subluxation, probable chronic ACL tear, probable chronic degenerative loss of anterior horn and body of the lateral meniscus and loose bodies.

The patient has failed conservative treatment including therapy, activity restriction, bracing/orthotics and medications. She has the subjective findings which were consistent with meniscal injury and she has clinical signs and objective exam findings with Dr. As per the ODG's, the surgical procedure is recommended based upon the records provided.

**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)