

CORE 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 30, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving).

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

MD, 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/25/08, 12/10/08
ODG Guidelines and Treatment Guidelines
Office note, Dr. , 02/21/08
MRI left knee, 02/21/08, 09/10/08
Office notes, Dr. , 05/28/08, 07/01/08, 07/09/08, 08/20/08, 09/10/08, 11/11/08
Office note, Dr. , 06/12/08
Request for reconsideration, 11/20/08
Patient referral, 02/21/08, undated

Work status, Undated, 07/09/08 07/01/08, 08/20/08, 09/10/08
Demographics, 09/26/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx-year-old injured on xx/xx/xx when she tripped and twisted her knee. She had a lateral meniscus tear and an anterior cruciate ligament (ACL) tear by MRI and surgery was done in March 2008 for an ACL reconstruction and at least a synovectomy. The claimant papers to have had postoperative rehabilitation of the knee.

On 07/09/08 Dr. noted the claimant reported night pain. An injection had been provided on 07/01/08 with 1-2 days relief. On examination there was no effusion but she had quadriceps weakness. There was full motion with no instability. Medication and work restrictions were recommended.

On 09/10/08 Dr. noted the claimant had some popping but no instability. On examination there was slight effusion. Quadriceps weakness persistent. The claimant was tender over the medial joint line and palpation of the condyle in flexion was painful. There was negative anterior drawer and pain with McMurray. The 09/10/08 MRI of the left knee showed tearing of the graft with a lax appearance. There was absence of the anterior horn of the lateral meniscus due to tearing or meniscectomy and a complex tearing of the body and posterior horn. Chondromalacia of the lateral tibia and patella was noted and there was a moderate effusion. There was a normal medial meniscus and ligaments.

The 11/11/08 note from Dr. indicated the claimant had medial knee pain with any weight bearing. Motion was 0-120 degrees. She was tender over the anteromedial joint space and medial joint line. There was popping of the lateral knee with no pain. There was no instability. Dr. noted he was not sure why she had medial pain but that she needed arthroscopy to debride the lateral meniscus and he also recommended Synvisc.

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

The patient has had an injection, complains of night pain, and symptoms of feeling like it is bone on bone. She has no effusion and full motion. Radiographs are unremarkable, but it is unclear whether or not these are weight bearing films. She has been taking anti-inflammatories and has been using a brace with restricted work hours. She has failed anterior cruciate ligament repair and had an MRI on 2/21/08 demonstrates complete ACL rupture with anterior translation with an effusion and lateral meniscal tear. In March 2008 she underwent anterior cruciate ligament reconstruction. It is unclear what is being treated by this surgery as the MRI of her left knee postoperative on 09/10/08 demonstrates a tearing of the graft with lax appearance, harvest of the patella, and normal medial meniscus. Based upon this symptomatology, complexity of this knee, arthroscopic addressing of the lateral meniscal pathology is not indicated by the subjective complaints of medial pain or objective findings. The patient does not meet the ODG indications for this surgery. The reviewer finds that medical necessity does not exist for Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving).

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):

1. Conservative Care: (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. 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.

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)