



Notice of Independent Review Decision

DATE OF REVIEW: 7/14/08

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for left knee arthroscopic partial medial meniscectomy with chondroplasty.

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

Texas licensed 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 previously denied request for left knee arthroscopic partial medial meniscectomy with chondroplasty.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax Cover Sheet/Comments dated 7/7/08, 7/3/08.
- Notice to CompPartners, Inc. of Case Assignment dated 7/7/08.

- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/3/08.
- Company Request for Independent Review Organization dated 7/3/08.
- Request Form Request for a Review by an Independent Review Organization dated 7/3/08.
- Fax Cover Sheet/Procedure Authorization Request dated 7/3/08, 6/9/08.
- Determination Notification Letter dated 6/25/08, 6/5/08.
- Report of Medical Evaluation dated 5/28/08, 2/18/08.
- Texas Workers' Compensation Work Status Report dated 5/28/08, 2/18/08.
- History and Physical Examination Report/Letter dated 5/28/08, 2/18/08.
- Follow-Up Evaluation Report dated 5/13/08, 3/4/08.
- Addendum Report/Letter dated 5/9/08.
- Letter of Medical Necessity dated 2/28/08.
- Note dated 2/20/08.
- Left Knee MRI dated 2/18/08, 6/6/07.
- New Patient Evaluation Report dated 1/8/08.
- Referral Form dated 11/30/07.
- Letter of Referral Request dated 11/29/07.
- Lumbar Spine MRI dated 6/7/07.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: xxxxx

Date of Injury: xx/xx/xx

Mechanism of Injury: Walking down a sidewalk and tripped.

Diagnosis: Left knee medial meniscus tear and chondromalacia

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

The claimant is a xx-year-old female who injured her low back and left knee on xx/xx/xx, when she was walking down a sidewalk and tripped. The diagnoses were left knee medial meniscus tear and chondromalacia. An MRI of the left knee was done on 06/06/07, and demonstrated a medial meniscal tear and she underwent left knee arthroscopy with partial medial meniscectomy and chondroplasty on 08/29/07. She continued to have left knee pain post operatively. Records indicated that she had some post op therapy in September 2007, but a request for therapy was not approved in November 2007. The claimant began treating with Dr. on 01/08/08, for persistent anterior and medial knee pain. Dr. indicated that the claimant had therapy and cortisone injections without benefit. She was taking Hydrocodone, Vicodin and Valium. On examination, she had no effusion; she had tenderness of the medial joint line and

positive McMurray. The diagnosis was left knee medial meniscus tear and left knee chondromalacia of the medial femoral condyle and patellofemoral joint. He noted that the claimant had failed conservative management with therapy for three months, analgesics and non-steroidal anti-inflammatory drugs (NSAIDs) and injections without benefit. Dr. recommended arthroscopic partial medial meniscectomy and chondroplasty. A 02/18/08 MRI of the left knee showed diffuse abnormal signal in the medial and lateral menisci compatible with myxoid degeneration and minimal joint effusion. The claimant was evaluated by Dr. on 02/18/08, who felt that she was not at maximum medical improvement (MMI) for the knee and felt that further surgery might be indicated. The claimant followed up with Dr. on 03/04/08, at which time, he recommended continued conservative care, but on 05/13/08, the claimant complained of her knee buckling and she had fallen six times. She was ambulating with a cane because the knee was very unsteady. The claimant had motion of 15-115 degrees and McMurray was positive. The impression was left knee medial meniscal tear and left knee chondromalacia. Dr. recommended left knee arthroscopy with partial medial meniscectomy and chondroplasty. Dr. evaluated the claimant again on 05/28/08 and agreed with Dr. recommendation. The requested left knee arthroscopy would be reasonable based on the claimant's persistent symptoms despite conservative measures. The claimant had a relatively normal MRI of the left knee on 02/18/08 but reported consistent symptoms of knee buckling with falling episodes. The claimant had known previous meniscal pathology and underwent a prior partial medial meniscectomy and chondroplasty on 08/29/07. Objectively, the claimant has a flexion contracture with motion from 15 to 115 degrees and a positive McMurray's test. It would be reasonable to pursue an arthroscopic evaluation given the physical exam findings and failure of conservative measures.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Knee: Chondroplasty Recommended as indicated below. ODG Indications for Surgery -- Chondroplasty: Criteria for chondroplasty (shaving or debridement of an articular surface): 1. Conservative Care: Medication. OR Physical therapy. PLUS 2. Subjective Clinical Findings: Joint pain. AND Swelling. PLUS 3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. (Washington, 2003) (Hunt, 2002) (Janecki, 1998) ODG Indications for Surgery -- Meniscectomy: Criteria for meniscectomy or meniscus repair: 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. (Washington, 2003).

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).