PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 03/27/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right knee diagnostic arthroscopy with or without synovial biopsy

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

X 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.

Right knee diagnostic arthroscopy with or without synovial biopsy - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 12/20/05, 12/27/05, 01/05/06, 01/12/06, 01/26/06, 02/01/06, 02/09/06, 02/23/06, 03/09/06, 03/30/06, 04/13/06, 05/01/06, 05/24/06,

06/16/06, 07/13/06, 08/17/06, 09/14/06, 10/18/06, 11/15/06, 12/13/06, and 01/10/07
X-rays of the knees interpreted by M.D. dated 12/20/05
A federal drug test custody and contract form dated 12/20/05
MRIs of the bilateral lower extremities interpreted by (no credentials were listed) dated 01/09/06
Laboratory studies dated 03/30/06 and 11/29/07
DWC-73 forms from Dr. dated 10/18/06, 01/10/07, 02/07/07, 03/07/07, 04/20/07, and 05/25/07
A Required Medical Evaluation (RME) with M.D. dated 10/19/06
A DWC-73 form from Dr. dated 10/19/06
DWC-73 forms from M.D. dated 11/06/06, 07/17/07
Designated Doctor Evaluations with M.D. dated 03/26/07 and 02/27/08
A psychological evaluation with L.P.C. dated 06/13/07
A Functional Capacity Evaluation (FCE) with D.C. dated 06/13/07
A letter from D.C. dated 06/26/07
Letters from Dr. dated 07/11/07 and 02/12/08
An evaluation with an unknown provider (signature was illegible) dated 07/26/07
A medication prescription from the same unknown provider dated 08/01/07
An evaluation with Dr. (no credentials were listed) dated 08/01/07
An IRO Decision from dated 08/21/07
Evaluations with M.D. dated 10/10/07, 11/05/07, 11/14/07, 11/29/07, 12/12/07, 12/19/07, 01/02/08, 01/23/08, and 02/13/08
X-rays of the knees interpreted by Dr. dated 10/10/07
An MRI of the right knee interpreted by M.D. dated 11/09/07
A sinus brachycardia report dated 11/29/07
An operative report from Dr. dated 12/10/07
A letter from Dr. dated 12/19/07
An impairment rating evaluation with Dr. dated 12/20/07
An authorization request from Dr. dated 01/07/08
A review from M.D. dated 01/09/08
Letters of denial, according to the ODG, from , Utilization Review Nurse, dated 01/10/08 and 01/30/08
A review from M.D. dated 01/29/08
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 12/20/05, Dr. recommended an ice cold pack, range of motion, and Lodine. X-rays of both knees interpreted by Dr. on 12/20/05 were normal. On 12/27/05, Dr. prescribed Vicodin and Naprosyn. An MRI of the right knee interpreted by Dr. on 01/09/06 revealed patellar edema that was a chronic finding and moderate joint effusion. On 02/09/06, Dr. recommended physical therapy. On 10/19/06, Dr. felt the patient's preexisting problems had been aggravated by his work injury and he recommended weight reduction and strengthening. On 03/26/07, Dr. placed the patient at MMI with a 1% whole person impairment

rating. On 06/13/07, Ms. recommended a work hardening program. Based on an FCE with Dr. on 06/13/07, 10 sessions of a work hardening program were recommended. On 10/10/07, Dr. recommended repeat MRIs of the bilateral knees and continued medication. X-rays of the knees interpreted by Dr. on 10/10/07 revealed decreased medial joint line space, superior and inferior poles of the patella, and hypertrophic changes. An MRI of the right knee interpreted by Dr. on 11/09/07 revealed tricompartmental degenerative changes. On 11/14/07, Dr recommended right knee surgery, Mobic, and Ultram ER. Right knee surgery was performed by Dr. on 12/10/07. On 12/20/07, Dr. felt the patient was not at MMI at that time. On 01/02/08, Dr. recommended Celebrex, Vicodin ES, and ACI knee surgery. On 01/09/08, Dr. wrote a letter of denial for the right knee surgery. On 01/10/08 and 01/30/08, Ms. wrote letters of denial for the ACI surgery. On 01/29/08, Dr. also wrote a letter of non-certification for the surgery. On 02/27/08, Dr. placed the patient at MMI with a 5% whole person impairment rating.

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

Based on the medical documentation provided for review, this appears to be a right knee arthroscopy that is being requested for ACI implantation. In my opinion, a repeat arthroscopy is not necessary. The patient has already had two arthroscopies, which have not provided long lasting relief. There are no new or intervening symptoms that would lead one to believe that another surgery would be necessary. In addition, I do not believe ACI would be reasonable at this point. The ODG relates that this is still largely an experimental procedure; however, in this patient it would be a particularly bad idea due to the fact the patient has moderate to severe chondromalacia in other compartments of the knee. This is a contraindication of ACI. This is also a contraindication to repeat scope. Thus, I the right knee diagnostic arthroscopy with or without synovial biopsy is not reasonable or necessary and this is in line with the ACOEM and ODG.

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

X **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
- [x] 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
- [ ] 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)