

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 5/2/2008  
**IRO CASE #:**

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

Right knee arthroscopy with partial medial meniscectomy (29881)

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer attended the University of Pittsburgh School of Medicine after completing his undergraduate degree at the University of Virginia. He completed an internship and residency at Pennsylvania State University. He has been actively practicing since 1990. He is a member of the American Academy of Orthopaedic Surgeons and the American Medical Association.

**REVIEW OUTCOME:**

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

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Right knee arthroscopy with partial medial meniscectomy (29881) Upheld

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This employee is a female who sustained an injury while at work. She felt immediate pain and swelling and was evaluated on 3/20/2008. A MRI reportedly confirmed the presence of a medial meniscal tear. A physical exam revealed the left knee had a slight effusion and there was near full range of motion.

At this time, the request for right knee arthroscopy with partial medial meniscectomy is under review.

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

The records reviewed support that the claimant is a woman with a diagnosis of torn medial meniscus, right knee. She was struck and run over by an electric wheelchair. An MRI on 03/12/2008 showed moderate degenerative changes in the medial compartment of the knee, medial subluxation of the meniscus, and a horizontal tear, chronic

Name: Patient\_Name

tear of the anterior cruciate ligament. Dr. noted that she had immediate pain and swelling at the time of the injury. He felt she had a medial meniscal tear, marked medial joint line tenderness, near full motion, and recommended arthroscopy. This was non-certified on 04/03/2008 by Dr. It was reviewed by Dr. 04/11/2008, non-certified.

Based on a review of the medical records provided and evidence-based medicine the request for right knee arthroscopy, partial medial meniscectomy is denied. The medical records do not document any evidence of locking or catching in this claimant's knee. It appears that she has a degenerative medial meniscus tear based on the MRI findings. There is no documentation that she has been treated with conservative measures including either cortisone injection for diagnostic potentially therapeutic modalities, anti-inflammatory medications, a home exercise program for stretching, strengthening, range of motion and modalities. Based on failure to document a positive McMurray's maneuver, or any locking, clicking, popping or conservative measures, at this time, the request for the proposed surgery cannot be recommended as medically indicated and necessary.

Therefore, the previous denial is upheld.

**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

**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)