

**Notice of Independent Review Decision**

**DATE OF REVIEW:**            10/18/2008

**IRO CASE #:**

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

Right knee arthroscopy with post-surgery radiation

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

Certified by the American Board of Orthopaedic Surgery, and fellowship-trained in surgery of the spine

**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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	836.0	29876	Overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Correspondence and documentation throughout the appeal process, including first and second level decision letters, reviews, fax cover sheets, pre-authorization requests, and request for review by an independent review organization

Medical notes dated 8/28/08, 8/7/08, 7/31/08, 7/24/08, 7/17/08, 7/15/08, 3/14/08, 1/8/08, 12/4/07, 10/22/07, 8/12/07, 8/6/07, 7/23/07, 7/16/07, 7/9/07, 6/18/07, 6/12/07, 4/30/07, 4/2/07, 3/1/07, 2/16/07, 2/5/07, 12/5/06, 11/2/06, 9/29/06, 8/28/06, 8/1/06

**Notice of Independent Review Decision**  
**Page 2**

MRI right knee dated 2/10/07  
Official Disability Guidelines not cited or provided

**PATIENT CLINICAL HISTORY:**

This a male who sustained an injury to his right knee in xx/xx while at work. He has had two arthroscopic surgeries to his right knee since then, and has traumatic arthropathy and scar tissue formation of the right knee. The claimant has increasing pain and discomfort in his right knee, with moderate to severe pain while standing or walking, and severe pain and catching in his right knee if he tries to kneel or squat. Conservative treatment has included straight leg raising exercise program, anti-inflammatory medication, and Supartz injections.

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

In the Reviewer's opinion, the requested surgery and post-surgery radiation should be authorized as requested for this patient. The Reviewer noted that the patient has had all appropriate treatment for his right knee pain, which has failed, and his symptoms meet the requirements listed under arthroscopy in the Official Disability Guidelines for repeat right knee arthroscopic surgery.

The Reviewer commented that this patient not only has severe pain in his knee, but also limited motion, catching, and positive McMurray testing (evaluates for tears in meniscus of knee). Given his overall symptoms and the objective findings, it is likely that he has a meniscus tear as well as the chronic synovitis and likely continued chronic chondral inflammation.

The Reviewer added that the use of radiation can be very helpful for patients with recurrent hypertrophic synovitis of the knee, such as this patient has, especially when the recurrent synovitis is present even after two prior surgeries. The Reviewer felt that the surgeon and the patient have carefully considered all treatment options, and in the Reviewer's opinion, the right knee arthroscopy with post-surgery radiation is medically necessary, appropriate treatment and should be approved as soon as possible.

**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**

**Notice of Independent Review Decision  
Page 3**

- 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)**