

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/27/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Knee Arthroscopy Surgery, Lateral Release and Tibia tubercle, 27418, 29876

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

OP report, 07/30/07

Office notes, Dr. , 01/18/08

Office notes, Dr. , 5/9/07, 7/18/07, 8/1/07, 8/10/07, 10/5/07, 02/08/08, 03/20/08, 04/23/08, 09/03/08, 10/01/08, 06/03/09

Functional capacity evaluation, 02/15/08

Progress note, 04/03/08

Consult, Dr. , 12/08/08

Second opinion, 02/17/09

Office note, Dr. , 06/01/09

Appeal, 06/25/09

MRI Right Knee, 4/24/07

MRI of the Lumbar Spine, 10/30/08

Dr. , MD, 1/7/08

, 9/20/07

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year old female who sustained an injury on xx/xx/xx when she hyper-extended her knee. She complained of pain. She underwent a right knee medial meniscectomy and

patellofemoral chondroplasty on 07/30/07. She had grade III chondromalacia of the medial femoral condyle. Following surgery she continued to have pain and diagnosed with reflex sympathetic dystrophy of the right knee. She had also undergone Synvisc injection and physical therapy with no relief. On physical exam dated 06/03/09 reports no swelling, no ecchymosis, no deformity but evidence of quadriceps atrophy and trace effusion. The exam also revealed crepitation on palpation with moderate pain and tenderness over the patella. There was full range of motion and no instability noted. The recommendation from Dr. is for a arthroscopic lateral release of the tibial tubercle.

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

The request was to determine the medical necessity of a lateral retinacular release and tibial tubercle osteotomy in this case. Typically, this procedure is reserved for individuals who have obvious extensor malalignment and for whom other more conservative treatments have failed. The records in this case do not make a compelling case for proceeding with surgery. This individual has already had surgery and it appears that the outcome of the surgical procedure was less than ideal. Furthermore, the postoperative course was complicated by severe pain. There was concern that the individual developed sympathetic dystrophy. Be that as it may, the records provided do not document extensor malalignment for which one would normally recommend a lateral release and/or tibial tubercle osteotomy. The report of surgery documented patellofemoral chondral change but did not make a convincing case that this was related to extensor malalignment. As such, the request for a surgical procedure in this case cannot be considered reasonable or medically necessary, as it does not meet the ODG indications for surgery. The reviewer finds that medical necessity does not exist for Right Knee Arthroscopy Surgery, Lateral Release and Tibia tubercle, 27418, 29876.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates knee lateral retinacular release

Recommended as indicated below.

ODG Indications for Surgery| -- Lateral retinacular release

Criteria for lateral retinacular release or patella tendon realignment or Maquet procedure

1. Conservative Care: Physical therapy (not required for acute patellar dislocation with associated intra-articular fracture). OR Medications. PLU
2. Subjective Clinical Findings: Knee pain with sitting. OR Pain with patellar/femoral movement. OR Recurrent dislocations. PLU
3. Objective Clinical Findings: Lateral tracking of the patella. OR Recurrent effusion. OR Patellar apprehension. OR Synovitis with or without crepitus. OR Increased Q angle >15 degrees. PLU
4. Imaging Clinical Findings: Abnormal patellar tilt on: x-ray, computed tomography (CT), or MRI

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

[] ACOEM-AMERICA 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)