



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 9/2/2009

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of arthroscopy with chondroplasty and lateral release of the left knee (29877 & 29873).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

**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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of arthroscopy with chondroplasty and lateral release of the left knee (29877 & 29873).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

, MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from : Pre-Authorization Form – undated; Denial Letter – 7/20/09 & 7/29/2009; Pre-Authorization Appeal Form – undated. Records reviewed from , MD: Office Notes – 4/18/08-7/31/09, Injection report – 8/5/08, Operative Report – 4/14/08 & 1/5/09.

A copy of the ODG was not provided by the Carrier or URA for this report.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx year old female who was injured on xx/xx/xx at work. She underwent left knee scope and chondroplasty on 4/14/08 and OATS procedure on 1/5/09. She was seen 6 times in follow-up through 6/23/09 for knee pain. She was found to have less pain at the site of the OATS procedure and more pain and crepitance producing pain in the patellofemoral joint. Cortisone and PT were of no long term benefit. The patient is now being recommended for left knee scope, chondroplasty and lateral retinacular release.

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

According to the ODG: Patient has fully documented indications one thru three and has noted on arthroscopy a chondral defect. This surgical finding would be evident on MRI which is therefore an MRI is an unnecessary procedure which would lead to unnecessary expense.

**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.
- 4. Imaging Clinical Findings:** Chondral defect on MRI

**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
- 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)