



Notice of Independent Review Decision

DATE OF REVIEW: 4/8/10

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for:
Open excision of right tibial cyst with graft.

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

Texas licensed orthopedic surgeon.

REVIEW OUTCOME: APPROVED.

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)

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.

The previously denied request for: Open excision of right tibial cyst has been approved as medically indicated and necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Utilization Review Findings dated 3/25/10.
- Company Request for IRO dated 3/24/10.

- Request Form dated 3/24/10.
- Review Determination dated 3/17/10, 3/8/10.
- Right Knee MRI dated 2/16/10.
- Office Note dated 2/24/10, 2/3/10, 1/20/10, 12/16/09, 11/11/09, 10/6/09.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx
Gender: xxxxx
Date of Injury: xx/xx/xx
Mechanism of Injury: The claimant was performing an test on a while working and as the corner was turned the truck tipped and the bucket crashed to the ground striking and injuring the claimant's right knee.
Diagnosis: Fluid/ganglion cyst right knee.

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

DOCUMENTED DECISION: This is a male who sustained injury to his right knee on xx/xx/xx. He underwent several surgeries that included anterior cruciate ligament (ACL) revision and reconstruction on 5/22/08, partial medial meniscectomy, chondroplasty of inferior pole of patella, chondroplasty, and microfracture of lesion, in the medial femoral condyle on 10/2/08 and excision of cyst and debridement of osteophyte, over the screw head at the tibial tunnel, on 4/2/09. Incision and drainage for infection followed the 4/02/09 procedure. The claimant continued with anterior knee discomfort. An office note on 12/16/09 indicated pain, over the pes anserine bursa area, with slight fullness in the area and a moderate amount of scar tissue. Topical and oral non-steroidal anti-inflammatory drugs (NSAIDs) provided no significant benefit and phonophoresis, an immobilizer, along with continued therapy were advised. On 1/10/10, an area over the tibial drill tunnel site was slightly increased, suggesting cyst formation and a cortisone injection was administered without relief. A magnetic resonance imaging (MRI) on 02/16/10 noted a fluid/ganglion type cyst seen within the tibial tunnel, with the ganglion cyst extending into the subcutaneous tissue with internal enlargement of tibial tunnel associated with the cyst. Open excision of the tibial cyst with possible graft was recommended. The surgery was non-certified on two previous reviews.

A review of the records supported that the claimant was treated with a cortisone injection, medications and physical therapy, none of which helped. An MRI confirmed a large cyst which was expansive and they recommended a reattempt, at cauterization and bone plug. This reviewer would approve the surgery as medically indicated and necessary at this time to decrease symptomatology and gain functionality. Based on the records provided he had failed conservative care. The cyst appeared to be enlarging. Although the previous surgery was unsuccessful, it is reasonable to try an excision of the cyst with bone graft. This

condition is not addressed by ODG but would be supported by Install and Scott (2001)

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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,
(ODG, TREATMENT IN WORKER’S COMP, 14TH EDITION; 2010 UPDATES DO NOT ADDRESS.)
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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:
(SURGERY OF THE KNEE 3RD EDITION, INSTALL-SCOTT, 2001, CHAPTER 3, ANATOMIC ABERRATIONS, PAGE 88.)

