

SENT VIA EMAIL OR FAX ON  
Jun/05/2010

## Applied Assessments LLC

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Jun/05/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Outpatient right knee arthroscopy medial and lateral meniscectomies.

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

OD Guidelines  
X-ray right knee, 08/13/2008  
MRI right knee, 10/16/2008  
Office notes, Dr., 04/16/09, 04/22/09, 04/27/09, 05/15/09, 06/05/09, 06/17/09, 06/15/09, 07/30/09, 08/31/09, 09/29/09, 10/29/09, 11/24/09  
Office note, Dr. 12/16/09  
MRI right knee, 10/16/08  
Office note, Dr. 04/05/10  
264 pages from SORM 12/4/07 thru 5/17/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female claimant who sustained a slip and fall on xx/xx/xx which resulted in neck, left shoulder and right knee pain. An MRI of the right knee performed in 10/16/08 showed a minimal joint effusion, mild degenerative joint disease and tear of the posterior horn of the

medial meniscus. The physician records of 2009 centered around treatment for the claimant's cervical and shoulder pain and mentioned the claimant with right knee pain and buckling. A 04/05/10 physician record revealed the claimant with right knee pain with associated give way. Examination demonstrated tenderness in the popliteal area, mild effusion and positive

Mc Murray testing. The previous right knee MRI was reviewed. A right knee arthroscopy for medial meniscal repair or partial medial meniscectomy was recommended.

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

The requested right knee arthroscopy medial and lateral meniscectomy is not medically necessary based on a careful review of the records. This claimant is a 53-year-old woman who was injured in December 2007. There is an October 2008 MRI of the right knee report that describes a surface tear of the posterior horn medial meniscus. This report does not describe a significant joint effusion or displacement of the tear or an unstable pattern to the tear. There are then really no further treatment records for the right knee. On 12/16/09 Dr. Rosenberg, did an office visit but really did not document positive physical findings to the knee. On 04/05/10 Dr. Chau documented a mild effusion with tenderness and pain on McMurray's testing but did not document muscle atrophy weakness or limitation in motion and there is no documentation on any medical records of conservative care such as physical therapy, anti-inflammatory medication, home exercises or an injection. ODG Guidelines document the use of arthroscopic meniscectomy in patients who have pain, positive physical findings and limitation in function who have failed appropriate conservative care. In this case there is no documentation of any conservative care. The MRI is more than a year and one half old, and only shows a surface tear without meniscal displacement. Therefore in light of the fact that there is no documentation of conservative care and no documentation of muscle atrophy or weakness which one might expect in someone who has a symptomatic meniscus for more than a year and a half. The requested surgical intervention is not medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Knee and Leg :  
Meniscectomy

ODG Indications for Surgery™ -- Meniscectomy:

**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)