

SENT VIA EMAIL OR FAX ON  
May/26/2010

**True Decisions Inc.**  
An Independent Review Organization  
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**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**  
May/24/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Right Knee Scope, Meniscal Surgery, Chondroplasty

**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  
Office notes Dr. 09/09/09, 09/24/09, 11/02/09, 11/30/09, 12/10/09, 01/11/10, 02/10/10  
MRI left knee 09/16/09  
Operative report 12/08/09  
Physician discharge summary 12/08/09  
Peer review 03/08/10  
Peer review 04/02/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male claimant with reported bilateral knee injuries on xx/xx/xx after a fall down a flight of stairs. A right knee MRI dated 09/16/09 showed myxoid degeneration with the posterior horn of the medial meniscus without a tear, findings consistent with posttraumatic hematoma or bursitis, patellar tendinopathy and mild cartilage fissuring along the patellar facets. A left knee MRI also performed on 09/16/09 showed myxoid degeneration with the posterior horn of the medial meniscus without a tear, patellar tendinopathy and focal cartilage

erosive change along the lateral aspect of the medial femoral condyle. Continued discomfort in both knees was reported despite conservative treatment, which included physical therapy and anti-inflammatory medication. The claimant subsequently underwent a left knee lateral partial meniscectomy and chondroplasty in December 2009. Physician records in January 2010 noted that the claimant was doing well with the left knee but that he complaints of right knee discomfort. A follow up physician record dated 02/10/10 revealed the claimant with continued right knee symptoms, which included a sense of instability with buckling, catching and popping with walking. A right knee scope, meniscal surgery, chondroplasty was recommended.

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

Medical necessity for right knee scope, meniscal surgery, chondroplasty.

Based upon my review of the records provided and evidence based medicine, there is supportive evidence for the medical necessity of right knee arthroscopic surgery. The claimant has failed conservative care after an injury on xx/xx/xxx and was treated with anti-inflammatory medications, physical therapy, cortisone injection that was diagnostic and was helping for 4-5 days and then he had the recurrence of his symptoms. At this juncture I would approve as medical necessary, the right knee meniscal surgery and chondroplasty; this would be a diagnostic and potential therapeutic modality and is consistent with evidence based medicine and ODG Guidelines and the claimant's failure of conservative care to include physical therapy, medications, and activity modifications. There are supportive findings of joint pain, the feeling of giving way with a sense of instability and popping, and the MRI showed myxoid degenerative menisci and prepatellar fluid consistent with injury.

Examination findings note patella femoral discomfort with catching and popping, based on the above and consistent with evidence-based medicine, this is medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Knee :  
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)