

Notice of Independent Review Decision

DATE OF REVIEW: MAY 18, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Knee Arthroscopy.

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

This physician is a Board Certified Orthopedic Surgeon with 35 years of experience as an orthopedic surgeon and a member of the American Academy of Orthopaedic Surgeons.

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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On xx/xx/xx ROM and CMT testing was completed. The claimant's ROM of his right knee was measured at 93°.

On May 30, 2008, MRI of the right knee was performed, read by, M.D. Impression: Mild degenerative changes in the posterior horns of both the medial and lateral menisci. Otherwise unremarkable appearance of the knee.

On December 29, 2008, MRI of the right knee with 3D C/S Contrast was performed, read by M.D. Impression: Intact cruciate ligaments. Grade II signal changes body of medial meniscus without discrete tear. No bone injury is seen.

On June 3, 2009, M.D. evaluated the claimant. Per Dr. report: The claimant was seen by Dr., an orthopedic surgeon, x-rays were taken and the claimant was placed in a knee brace. The claimant was then under the care of Dr., where he underwent a course of physical therapy. Dr. noted that the claimant is currently wearing a knee brace. Dr. also noted mild tenderness, minimal swelling, and decrease ROM. Impression: Internal derangement of the knee and right knee sprain.

On March 1, 2010, M.D., an orthopedic surgeon, evaluated the claimant. Dr. noted the claimant is currently wearing a knee brace. Dr. notes tenderness in the medial aspect of the right knee and good ROM. The claimant has pain with varus and valgus stress. The claimant has no instability noted. There is a popping sensation with internal and external rotation, with pain. X-rays of the claimant right knee were obtained with no bony abnormalities no fractures, and no subluxation. Procedure: Betamethansone was injected into the right suprapatellar space. Impression: Internal derangement.

On March 17, 2010, Dr. re-examined the claimant. With regard to claimant's right knee, he has exhausted all reasonable non-operative treatment that includes physical therapy, over-the-counter medications, and injections without relief. He continues to have pain with functional limitations, which requires him to use a knee brace and a walking cane for assistance. I would recommend proceeding with a diagnostics arthroscopy of this right knee. Left knee ROM was measured at 93°.

On April 22, 2010, M.D., an orthopedic surgeon, performed a utilization review on the claimant. Position: It has not been clear whether the claimant has been wearing his knee brace for this entire prior of time and it is not clear what exact physical therapy modalities were used with respect to the claimant's treatment. The claimant's MRI reports do not reveal any evidence of a mechanical or an internal derangement within the knee that could cause such symptomatology. There is no evidence of a cruciate ligament tear, a meniscal tear, an osteochondral lesion, a loose body, or any other objective findings. The request for right knee arthroscopy cannot be considered medically appropriate or medically necessary.

On April 30, 2010, M.D., an orthopedic surgeon, performed a utilization review on the claimant. Position: There is insufficient documentation to justify preauthorization of meniscectomy and lateral retinacular release. I made 2 reasonable attempts to contact the provider for additional information and I have not received a call back.

PATIENT CLINICAL HISTORY:

On xx/xx/xx the claimant injured his right knee when he twisted his right while stepping on an object. The claimant reported that he felt a pop and fell down.

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

The claimant has failed with conservative care in the form of physical therapy, medications, and injections per the documentation from Dr. and Dr.. The claimant still presents with pain and functional limitations since his injury on xx/xx/xx despite conservative care. Based on the ODG Guidelines the right knee diagnostic arthroscopy is indicated; therefore, the decisions are overturned.

Diagnostic arthroscopy	Recommended as indicated below. Second look arthroscopy is only recommended in case of complications from OATS or ACI procedures, to assess how the repair is healing, or in individual cases that are ethically defensible for scientific reasons, only after a thorough and full informed consent procedure. (Vanlauwe, 2007) ODG Indications for Surgery™ -- Diagnostic arthroscopy: Criteria for diagnostic arthroscopy: 1. Conservative Care: Medications. OR Physical therapy. PLUS 2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS 3. Imaging Clinical Findings: Imaging is inconclusive. (Washington, 2003) (Lee, 2004)
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**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)