

SENT VIA EMAIL OR FAX ON  
May/18/2010

## True Decisions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
May/17/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Right knee arthroscopy, partial medial menisectomy, possible 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  
Letter, 04/14/10  
Review, Dr. 04/15/10  
Review, Dr. 04/23/10  
MRI right knee, 03/29/10  
Office note, Dr. 04/07/10  
Letter, Dr. 04/16/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female who reported a right knee injury on xx/xx/xx when she stepped off a rock, rolled her ankle and twisted her right knee. She reported hearing a pop with sudden onset of pain and swelling. Initial treatment records were not available for review. Right knee MRI evaluation performed on 03/29/10 showed complex tear of both the radial and horizontal components of the posterior horn medial meniscus and horizontal oblique tear of the body of the medial meniscus with intact anterior horn; grade I medial collateral ligament sprain; mild

to moderate chondromalacia median ridge and medial facet of the patella with the patella being well positioned in the groove; mild diffuse chondromalacia of the lateral femoral condyle; mild to moderate diffuse chondromalacia of the weight bearing portion of the medial femoral condyle; intact extensor mechanism, anterior cruciate ligament and posterior cruciate ligament; moderate effusion; and normal lateral meniscus without degeneration or tear. Dr. saw the claimant for orthopedic evaluation on 04/07/10 with physical examination findings of marked antalgic gait; wearing a brace; limited motion of 5-110 degrees; 4/5 strength limited by pain; at least 2+ to 3+ effusion; markedly tender medial joint line and medial meniscus region; markedly positive medial McMurray's and medial Apley; good stability; and negative lateral meniscus examination. Arthroscopy was recommended. Reviews were provided for denial of arthroscopy right knee with partial meniscectomy and possible chondroplasty. Reference was made to use of anti-inflammatories, bracing, recommendation for rehabilitation, and activity modification. Notation was made that the submitted code for prior review was for lateral and meniscal repair. As there were no lateral meniscus findings, surgery to include lateral meniscectomy was denied. The reviews indicated discussion with Dr. that indicated the claimant was having episodes of locking and catching with limited range of motion and extensor lag. Dr. reportedly related treatment consisting of anti-inflammatories and activity modification. A letter from Dr. dated 04/16/10 noted physical therapy was contraindicated with mechanical symptoms and surgical intervention was needed.

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

The requested right knee arthroscopy, partial medial meniscectomy and possible chondroplasty are medically necessary based on review of this medical record.

This is a woman who was injured xx/xx/xx. There is no documentation in any of the medical records of a prior problem. The medical records document an MRI with a complex tear of the posterior medial meniscus as well as chondromalacia. The treatment records of Dr. xxxxx document pain and positive mechanical findings and lack of prior issue with the knee. Dr. xxxxx documents positive physical findings to include an antalgic gait, limited range of motion, and effusion with tenderness and positive McMurray's and Apley testing.

ODG guidelines document the use meniscectomy in patients who have conservative care unless there are significant mechanical issues, ongoing subjective complaints, positive physical findings, and abnormal diagnostic testing. In light of the fact that Dr. has written a letter of appeal 04/16/10 documenting her significant mechanical issues, and his treatment records document positive physical findings and failure of a short of conservative care, then the requested surgical intervention is medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 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)