



IRO# 5356
5068 West Plano Parkway Suite 122
Plano, Texas 75093
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Notice of Independent Review Decision

DATE OF REVIEW: 04/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right knee arthroscopy, lateral release and medial plica excision

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery
Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Right knee arthroscopy, lateral release and medial plica excision		-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		16	04/07/2010	04/07/2010
2	IRO Record Receipt		9	10/13/2009	02/02/2010

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a male with a history of right knee injury. The mechanism of injury is not documented. The current request is for preauthorization of right knee arthroscopic surgery, lateral retinacular release, and medial plica excision. The request has been considered and preauthorization was denied; it was

reconsidered and denied. Apparently, this patient has had 2 prior surgeries, 07/14/08 and 07/13/2009. The diagnosis is patellofemoral pain.

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

It does not appear that this patient has satisfied criteria published in the ODG, 2010, knee chapter and cited below. The medical records submitted with this request do not document the clinical findings other than knee pain on the basis of patellofemoral pain syndrome. Non operative treatment is documented with non steroidal anti inflammatory drugs and a non specific brace. Intra-articular steroid injections are not documented. Medical necessity for arthroscopic surgery for lateral retinacular release has not been established. The prior denials were appropriate and should be upheld.

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

Lateral retinacular release	<p>Recommended as indicated below.</p> <p>ODG Indications for Surgery™ -- Lateral retinacular release: Criteria for lateral retinacular release or patella tendon realignment or maquet procedure:</p> <p>1. Conservative Care: Physical therapy (not required for acute patellar dislocation with associated intra-articular fracture). OR Medications. PLUS</p> <p>2. Subjective Clinical Findings: Knee pain with sitting. OR Pain with patellar/femoral movement. OR Recurrent dislocations. PLUS</p> <p>3. Objective Clinical Findings: Lateral tracking of the patella. OR Recurrent effusion. OR Patellar apprehension. OR Synovitis with or without crepitus. OR Increased Q angle >15 degrees. PLUS</p> <p>4. Imaging Clinical Findings: Abnormal patellar tilt on: x-ray, computed tomography (CT), or MRI.</p> <p>(Washington, 2003) (Fithian, 2004) (Aderinto, 2002) (Naranja, 1996) (Radin, 1993)</p>
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- 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)**

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 04/22/2010.