

# I-Decisions Inc.

An Independent Review Organization  
5501 A Balcones Drive, #264  
Austin, TX 78731  
Phone: (512) 394-8504  
Fax: (207) 470-1032  
Email: manager@i-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/05/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

1 Right Knee Arthroscopy With Possible Chondroplasty of the Patellofemoral Joint

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

M.D., 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)

The reviewer finds that medical necessity exists for 1 Right Knee Arthroscopy. The reviewer finds that medical necessity does not exist for Possible Chondroplasty of the Patellofemoral Joint.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines

1/20/10, 3/12/10

Office notes, Dr. 06/22/09, 08/07/09, 01/11/10

MRI right knee, 07/24/09

RME, Dr. 10/21/09

Peer review, Dr. 01/20/10

Record review, Dr. 01/27/10

Peer review, Dr. 03/12/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female with right knee pain after falling onto her knee on xx/xx/xx. The MRI of the right knee from 07/24/09 showed no significant abnormality and borderline medial patella subluxation. On 08/27/09, Dr. performed an injection. Dr. performed a required medical examination on 10/21/09. The claimant reported that the corticosteroid injection helped for 2 months and the pain returned three weeks ago. Examination revealed right knee medial joint line tenderness, pain with distraction of the patella and right knee range of motion from 0 to

140 degrees. Diagnosis was knee contusion. Dr. placed the claimant at 0 percent whole person impairment. On 01/11/10, Dr. noted that physical therapy was denied by the insurance carrier and that the claimant's symptoms were primarily patellofemoral. On 01/27/10, Dr. noted a history of 12/19/08 and 04/06/09 injection. Dr. recommended a home exercise program. The claimant has treated with Mobic, Xanax and Wellbutrin.

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

The requested right knee arthroscopy is medically necessary, however the requested chondroplasty of the Patellofemoral Joint is not. This is a woman who has had ongoing right knee complaints following an xx/xx/xx injury where she fell. She has been treated conservatively and underwent MRI documenting no significant abnormality. She had injection, physical therapy, anti-inflammatory medication, the injection was in August 2009 and it has helped for two months. The most recent medical record is a 01/11/10 office visit of Dr. who indicates that the patient continues to have positive patellar femoral pain with compression and positive medial lateral facet tenderness and he wants to do a right knee arthroscopy with possible chondroplasty versed medial plica incision depending on findings. ODG Guidelines document the use of diagnostic arthroscopy in claimants who have ongoing symptoms and have failed appropriate conservative care even with normal diagnostic testing, that appear to be the case in this claimant and that appears to be the case and the diagnostic arthroscopy meets the criteria. ODG Guidelines describe the necessity of objective clinical findings to include effusion or crepitance or limited range of motion and a chondral defect on MRI none of which is present in this case. Based on the ODG, the right knee arthroscopy would be medically necessary however, the chondroplasty, would not be medically necessary. The reviewer finds that medical necessity exists for 1 Right Knee Arthroscopy. The reviewer finds that medical necessity does not exist for Possible Chondroplasty of the Patellofemoral Joint.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter knee, diagnostic arthroscopy, chondroplasty.

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)

ODG Indications for Surgery| -- Chondroplasty

Criteria for chondroplasty (shaving or debridement of an articular surface)

1. Conservative Care: Medication. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Joint pain. AND Swelling. PLUS
3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion
4. Imaging Clinical Findings: Chondral defect on MRI

(Washington, 2003) (Hunt, 2002) (Janecki, 1998)

**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)