

## Notice of Independent Review Decision

### PEER REVIEWER FINAL REPORT

**DATE OF REVIEW:** 9/16/2010  
**IRO CASE #:**

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

1. Right knee diagnostic arthroscopy with possible patellar chondroplasty, lateral release, possible open vastus medialis obliquus (VMO) plication and/or medical retinacular reconstruction and treatment as indicated and Cryo rental for 7 days post operation.

**QUALIFICATIONS OF THE REVIEWER:**

Orthopaedics, Surgery Trauma

**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)

1. Right knee diagnostic arthroscopy with possible patellar chondroplasty, lateral release, possible open vastus medialis obliquus (VMO) plication and/or medical retinacular reconstruction and treatment as indicated and Cryo rental for 7 days post operation. Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Facsimile cover sheet by dated 8/27/2010
2. Advanced medical review of case assignment by dated 8/27/2010
3. Review request by author illegible dated 8/26/2010
4. Request for a review by an independent review organization by author illegible dated 8/13/2010
5. Review determination by author unknown dated 7/8/2010-7/26/2010 multiple dates
6. Demographics report by, MD dated 7/6/2010
7. Progress note by, PT dated 5/7/2010
8. Follow-up note by, MD dated 4/1/2010-6/29/2010 multiple dates
9. MRI report of the right knee by, MD dated 3/29/2010
10. Initial consultation by, MD dated 3/23/2010
11. Patient clinical report by author illegible dated 3/8/2010-3/17/2010 multiple dates
12. Radiology report by, MD dated 3/8/2010

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

the injured employee (IE), is a male who has right knee and right ankle injuries. His date of injury was xx/xx/xx. He stated his knee "popped out and then popped back in."

An MRI completed 3/29/10 revealed all ligaments were intact, bone marrow edema, and possible partial tear of retinaculum. According to the follow-up note by, MD, dated 6/29/2010, despite conservative TX including bracing, PT, NSAIDs and time, the right knee has plateaued still having anteromedial pain with knee flexion-loading activities. There is lateral patellar maltracking and there is a negative patellar apprehension test. The patella was noted to be stable.

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

The injured employee's history is above. ODG criteria are as follows:

Criteria for diagnostic arthroscopy:

1. Conservative Care: Medications. OR Physical therapy. PLUS  
- This criterion is met
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS

Name: Patient\_Name

- The injured employee continues to have pain

3. Imaging Clinical Findings: Imaging is inconclusive.

- MRI does not demonstrate chondral defect

Criteria for chondroplasty (shaving or debridement of an articular surface), requiring ALL of the following:

1. Conservative Care: Medication. OR Physical therapy. PLUS

- This criteria is met

2. Subjective Clinical Findings: Joint pain. AND Swelling. PLUS

- There is joint pain, not swelling

3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS

- There is no effusion: there is crepitus and there is no exact documentation of ROM

4. Imaging Clinical Findings: Chondral defect on MRI

- This criterion is not met.

Cryotherapy is not supported in the literature as improving the functional results and is not medical necessary. It is not the standard of care.

Overall, there is not adequate documentation of meeting ODG criteria. There is no clear radiographic documentation of chondral defect for chondroplasty. There is a negative patellar apprehension test and the patella was noted to be stable. There is not adequate clinical and radiographic documentation for the requested procedure. The recommendation is to uphold the previous denial.

**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)

J Bone Joint Surg Am. 2010 Apr;92(4):994-1009. Management of articular cartilage defects of the knee.  
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