

# Prime 400 LLC

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE OF REVIEW:

Sep/28/2010

### IRO CASE #:

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

1 Left Knee Arthroscopy with Chondroplasty

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

MD, 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

ODG Indications for Surgery – Arthroscopy/Chondroplasty

Dr. OV 06/23/10 , 07/29/10

MRI left knee 01/19/09 , 04/20/10

Operative report 10/08/09

Physical Therapy Records 10/13/09, 11/04/09 , 05/06/10, 05/26/10, 06/04/10

MD Rx 05/03/10

Peer Review 07/21/10, 08/02/10

MD surgery orders

, 7/21/10, 8/2/10

### PATIENT CLINICAL HISTORY SUMMARY

This is a male with a long history of left anterior knee pain. Left knee arthroscopy, arthroscopic lateral release and chondroplasty of medial femoral condyle was performed on 10/8/09. The claimant then reportedly sustained a fall on xx/xx/xx that resulted in a left knee dislocated patella. A physical therapy record of 05/06/10 noted the claimant with left knee pain. A follow up physician record dated 07/29/10 revealed the claimant continued to be symptomatic despite a course of physical therapy, medication and injection and modified duty. The claimant was diagnosed with left knee patellar chondromalacia and a left knee arthroscopy with chondroplasty patella was recommended.

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

Based on the information reviewed, I cannot recommend the proposed surgery as medically necessary at this time. One major issue appears to be laterality. It is unclear if on the 07/29/10 visit Dr. was discussing treatment to the left knee in the form of injections therapy, cortisone, physical therapy and NSAIDS. It does appear the claimant had a recent left patellofemoral dislocation. This is based on review on the records provided and the evidence based medicine. The reviewer finds that medical necessity does not exist at this time for 1 Left Knee Arthroscopy with Chondroplasty.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Knee and Leg:

## Chondroplasty

Recommended as indicated below. Not recommended as a primary treatment for osteoarthritis, since arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical therapy and medical treatment. (Kirkley, 2008) See also Meniscectomy

### ODG Indications for Surgery | -- Chondroplasty

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

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. PLUS
4. Imaging Clinical Findings: Chondral defect on MRI

### **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)