

Notice of Independent Review Decision

DATE OF REVIEW: 9/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for left knee diagnostic and operative arthroscopy

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

The physician providing this review is Board Certified, American Board of Orthopaedic Surgery. He has received honors and awards for his research and is a published writer of professional literature and abstracts as well as contributions to texts books. He has been in private practice since 2001.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Based on the information reviewed, the repeat left knee diagnostic arthroscopy is not medically indicated and appropriate at this time.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records received: 19 page fax on 9/14/2010 Texas Department of Insurance IRO request, 17 page fax on 9/20/2010 URA Response to disputed services with notes from MD, 23 page fax on 9/21/2010 from physician with office visit documentation and 76 page fax on 9/21/2010 from physician with office visit documentation, including administrative and medical records.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female who was status post diagnostic and operative arthroscopy left knee, lateral retinacular release left knee, lysis and excision of suprapatellar and infrapatellar plica/bands. Dr. saw the claimant at one month postoperative. Examination revealed flexion to 90 degrees, full extension and able to weight bear. Physical therapy and medication was recommended. The MRI of the left knee, dated 01/15/10, revealed status post surgical lateral patellar retinacular release with normal patellofemoral joint alignment and mild chondromalacia of the medial patellar facet and patellofemoral trochlear. The body of the report documented grade 3 chondromalacia in the patellofemoral trochlea, mild chondromalacia of the medial patellar facet and mild deformity of the subchondral bone at the medial patella. Dr. saw the claimant on and reviewed the MRI. Continued physical therapy and return to work was recommended. Dr. performed a designated doctor's examination on 02/19/10. There was weakness to the quadriceps and hamstring on the left. Dr. stated that the claimant would be at maximum medical improvement on 06/01/10. On 03/04/10, Dr. saw the claimant. The claimant reported less pain and difficulty ascending and descending stairs. The claimant had full extension and flexion was to 110 degrees. Medication was recommended. Dr. saw the claimant on 05/21/10. Dr. stated that the recent MRI showed chondral changes to the left patella and that the claimant may need an abrasion chondroplasty. On 07/09/10, Dr. saw the claimant. The claimant was taking hydrocodone and Ibuprofen. Examination revealed that the claimant could walk on her heels and toes. Dr. recommended an abrasion chondroplasty.

The DYLL REVIEW

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

It is unclear if the claimant has exhausted conservative care with cortisone injections, and Viscosupplementation. This reviewer would recommend an Independent Medical Evaluation or DDE to assess subjective complaints in conjunction with normal physical examination findings and diagnostic testing including MRI and arthroscopy. The physical examination in the past showed no effusion, normal tracking and normal range of motion with mild weakness.

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

ODG Indications for Surgery™ -- Diagnostic arthroscopy:

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- 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)