



Southwestern Forensic  
Associates, Inc.

**REVIEWER'S REPORT**

**IRO CASE #:**

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

Knee arthroscopy with synovectomy, meniscectomy, abrasive chondroplasty, debridement, and microfracture

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering knee problems

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. Forensic Associates forms
2. TDI referral forms
3. Fax cover sheets
4. Denial letters, 06/23/10 and 07/27/10
5. Requestor records
6. Clinical notes, ten entries between 07/08/10 and 06/19/09
7. EKG
8. Urinalysis, lab, chemistries, all dated 06/02/10
9. Functional Capacity Evaluation, 04/21/10
10. Physician Release for Functional Capacity Evaluation, 03/29/10, unsigned
11. Chest x-ray and EKG, 11/23/09
12. Physical therapy notes, ten entries between 10/09/09 and 11/19/09
13. Left knee x-rays, 10/07/09 and 09/16/09
14. MRI scan, left knee, 09/24/09
15. URA records, UR referral forms

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient is male who suffered a twisting injury and direct blow injury to his left knee while attempting to move a refrigerator on the stairs in through a door. He apparently fell between the refrigerator and the wall. He suffers prolonged pain in the knee and joint line tenderness. His range of motion is diminished. He has exquisite tenderness. His MRI scan has revealed chondromalacia of the medial femoral condyle and the lateral femoral condyle in the region of the notch. He has been treated with physical therapy. The documentation of additional treatment utilizing medications or intraarticular cortisone injections is not present. The patient has been treated with activity modifications as he has not returned to work. A request was submitted for preauthorization for an arthroscopic surgical procedure including abrasive chondroplasty, meniscectomy of medial or lateral meniscus, synovectomy, and debridement chondroplasty, the CPT codes being 29879, 29881, 29875, and 29877. The request for the preauthorization of the arthroscopic surgical procedure was considered and denied, reconsidered and denied.

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

The nonoperative treatment of this patient's knee pain has not been accurately documented, the medications utilized, the extent to which medication have been effective, and the physical therapy reported some lack of complete compliance on the part of the patient with physical therapy program. The request for extensive arthroscopic surgery including meniscectomy, synovectomy, chondroplasty, and microfracture is not supported by diagnosis of pathology which would warrant such a surgical procedure. The prior denials of this request were appropriate and should be upheld.

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

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines, 2008, Cervical Spine Chapter, Discography passage.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.

- \_\_\_\_\_ Texas TACADA Guidelines.
- \_\_\_\_\_ TMF Screening Criteria Manual.
- \_\_\_\_\_ Peer reviewed national accepted medical literature (provide a description).
- \_\_\_\_\_ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)