

# I-Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/30/2011

### IRO CASE #:

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

Left Knee Arthroscopy Medial Meniscectomy, Lateral Femoral Condyle Chondroplasty Micro Fracture Drilling, and Debridement of ACL and (14) Day Rental of CPM Machine

### 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)

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

#### PATIENT CLINICAL HISTORY SUMMARY

This is a XX year-old male who reportedly injured his left knee on XX/XX/XX when exiting a truck; he felt a pop in the knee with associated pain and swelling. The claimant was noted to be status post prior anterior cruciate ligament reconstruction. A left knee x-ray performed on 10/29/10 showed questionable post surgical changes about the left knee, a possible loose body in the central knee left knee joint, a small effusion and probable bone island in the distal medial posterior left femur. A left knee MRI followed on 11/18/10 and showed status post anterior cruciate ligament (ACL) with substantial strain of the proximal portion of the ACL appearing to be present with at least some fibers appeared to remain intact, a vertical tear of the medial horn of the medial meniscus, a mild strain of the medial collateral ligament, a probable loose body within the joint centrally, probable bone islands in the distal femur, a small joint effusion and irregular cartilage of the lateral femoral condyle. A physician visit dated 12/06/10 noted the claimant with left knee pain. The previous x-ray and MRI was reviewed. A left knee medial meniscus tear, left knee lateral condyle chondral lesion and ACL strain versus a tear was diagnosed. Arthroscopic surgery to address the meniscus and chondral lesion was recommended. A follow up physician record of 02/08/11 revealed the claimant with continued knee problems with no new traumatic injury reported. Left knee examination findings included a trace effusion, tenderness over the joint line medially and laterally and positive Lachman's, Anterior drawer and pivot shift testing. Due to findings of instability, a left knee revision ACL reconstruction, partial medial meniscectomy and lateral condyle chondroplasty versus arthroscopic drilling was recommended along with a continuous passive motion machine for post-operative use.

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

The reviewer finds Left Knee Arthroscopy Medial Menisectomy, Lateral Femoral Condyle Chondroplasty Micro Fracture Drilling, and Debridement of ACL and (14) Day Rental of CPM Machine is not medically necessary.

A review of the records provided supports the claimant is a XX year-old male. He reported exiting a truck at work and felt a pop in his knee with swelling and pain on XX/XX/XX. The X-rays on 10/29/10 showed post-operative change about the left knee, possible loose body with effusion. The MRI of the left knee shows status post ACL reconstruction in the past with a strain, a tear of the medial meniscus, strain of the MCL likely loose body and a small joint effusion with cartilage irregularities, lateral femoral condyle.

The claimant saw Dr. on 12/06/10 who noted the history on examination, range of motion 0-110 and stable with tenderness with a positive McMurray's. The Lachman showed a poor end point but the claimant did not appear to be grossly loose, one plus laxity was noted. He reviewed the X-ray and the MRI, he noted there was not reactive bone contusion, he did note the chondral changes and recommended left knee arthroscopic surgery to address the meniscus and chondral lesion and to evaluate the ACL.

The claimant was treated with physical therapy per the records provided and followed up with Dr. on 02/08/11 noting knee pain when the knee was flexed, a feeling of instability. At that time he noted positive Lachman's, positive anterior drawer, positive pivot shift but no gross instability. He felt the claimant had left knee medial meniscus tear, lateral femoral condyle fracture and a recurrent ACL tear and recommended "left knee revision ACL reconstruction, partial medial menisectomy, and lateral femoral condyle chondroplasty versus arthroscopic drilling."

The requested surgery that was denied is different from the treating doctor's request: Dr. recommended a revision of the ACL on 2/8/11. This is not requested under the items for dispute.

Dr. notes that there is no full thickness cartilage lesion that requires drilling but rather the claimant would likely benefit from chondroplasty. The reviewer will uphold denial for the surgery, as the requested surgery is different from the treating doctor's request. This is based on review of the Official Disability Guidelines and review of the record provided. The reviewer finds no medical necessity for Left Knee Arthroscopy Medial Menisectomy, Lateral Femoral Condyle Chondroplasty Micro Fracture Drilling, and Debridement of ACL and (14) Day Rental of CPM Machine.

**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)