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Notice of Independent Review Decision

Reviewer's Report

DATE OF REVIEW: March 29, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Closed treatment of patellar fracture without manipulation, arthroscopically aided treatment of the intercondylar spine and/or tuberosity fracture of the knee with or without manipulation with internal or external fixation includes arthroscopy CPT 29851, 27520.

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

M.D., Board Certified in Orthopedic Surgery.

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)

The requested service, closed treatment of patellar fracture without manipulation, arthroscopically aided treatment of the intercondylar spine and/or tuberosity fracture of the knee with or without manipulation with internal or external fixation includes arthroscopy CPT 29851, 27520, is not medically necessary for treatment of this patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 3/4/11.

2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 3/8/11.
3. Notice to IRO of Case Assignment dated 3/9/11.
4. Medical records from MD dated 2/24/11, 1/6/11 and 12/16/10.
5. Medical record from Clinic dated 12/22/10.
6. Medical record from Hospital dated 11/30/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

A review of the record indicates the patient injured his left knee on XX/XX/XX. Per an MRI on 12/22/10, the patient was diagnosed with a chondral lesion of the medial femoral condyle; full thickness cartilage loss along the medial femoral condyle (2.3 cm x 0.8 cm) with a large effusion of the knee. His symptoms have persisted since the date of injury, i.e., more than three months. A note from the patient's provider dated 1/17/11 states "we are going to schedule him for left knee arthroscopy with microfracture of the medial femoral condyle lesion..." The submitted documentation indicates the patient's provider requested authorization for "closed treatment of patellar fracture without manipulation, arthroscopically aided treatment of the intercondylar spine and/or tuberosity fracture of the knee with or without manipulation with internal or external fixation includes arthroscopy CPT 29851, 27520." The URA indicates the requested service is not medically necessary for treatment of the patient's medical condition. Specifically, the URA states that the medical records do not document any evidence of patellar fracture. Additionally, the Carrier states that while the medical records document discussion regarding microfracture of the medial femoral condyle, this is not the procedure that has been requested.

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

The requested procedure codes CPT 29851, arthroscopically aided treatment of intercondylar spine and/or tuberosity fracture of the knee with or without manipulation with internal or external fixation including arthroscope and CPT 27520, closed treatment of patellar fracture with manipulation, are not medically necessary for this patient. The submitted records indicate the patient has been diagnosed with chondromalacia, not a patellar fracture. In the provider's notes he discusses "microfracture repair" of the medial femoral condyle. No explanation for the discrepancy between the procedure discussed in the provider's notes and the procedures specified in the authorization request has been provided. The provider's records do not demonstrate the patient meets clinical indications for the CPT codes that have been requested. Therefore, I have determined the requested services are not medically necessary.

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)