



3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 4-27-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of arthroscopic examination under anesthesia of right knee.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years.

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 reviewer agrees with the previous adverse determination regarding the arthroscopic examination under anesthesia of right knee.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: MD

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from MD included MRI from Radiology 3-15-2011, MD reports 2-21-2011, 3-21-2011, 3-30-2011, 9-20-2010, 10-8-2010, 8-30-2010, 7-23-2010, 6-25-2010, 7-9-2010, 4-

30-2010, 5-26-2010, 4-16-2010, 4-19-2010, 3-8-2010, 3-24-2010, 2-19-2010, 2-22-2010, 1-22-2010, 2-5-2010, 12-23-2009, 1-8-2010, 12-11-2009, 11-18-2009, operative report 12-10-2009.

Records from included MDR paperwork, utilization findings 3-25-2011 and 4-6-2011, operative report 5-16-2006, MRI 11-10-2009,

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The sustained a twisting knee injury while working. He underwent surgical knee arthroscopic partial meniscectomy and chondroplasty surgery, 2 months post the DOI. Despite post-operative therapy, the claimant has had recurrent knee pain and has been considered for another arthroscopic procedure. A 3/11 dated MRI revealed "advanced" degenerative changes/tears. A 3/21/11 dated progress note discussed the persistent "severe pain and symptoms" and painful weight-bearing with crepitus. There was a consideration for knee replacement in the future, in addition to arthroscopic surgery.

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

The claimant's knee is clearly overwhelmingly degenerated and osteoarthritic in nature, both symptomatically and on examination, including on imaging. Arthroscopic surgery as proposed, especially without significant mechanical symptoms and without a prior documented comprehensive recent trial of non-operative treatment (such as viscosupplementation) is not reasonable or necessary as per applicable clinical guidelines. Criteria include both subjective and objective abnormalities, along with a failed reasonable and comprehensive non-op. protocol. The preceding has not been met, as per the records submitted for review, therefore the requested procedure is not recommended.

ODG Indications for Surgery -- Meniscectomy:

Meniscectomy Recommended as indicated below for symptomatic meniscal tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings. (Kirkley, 2008)
Criteria for meniscectomy or meniscus repair (Suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positive):
1. Conservative Care: (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. PLUS
2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS

3. Objective Clinical Findings (at least two): Positive McMurray's sign. OR Joint line tenderness. OR Effusion. OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS

4. Imaging Clinical Findings: (Not required for locked/blocked knee.) Meniscal tear on MRI. (Washington, 2003)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

ODG Indications for Surgery -- 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. 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

(Washington, 2003) (Hunt, 2002) (Janecki, 1998)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

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 KNOWLEDGBASE
- 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)