



MedHealth Review, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: 10/21/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a left knee EUA, diagnostic scope and medial debridement versus repair.

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. The 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 disagrees with the previous adverse determination regarding the prospective medical necessity of a left knee EUA, diagnostic scope and medial debridement versus repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr. and

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr: procedure to be scheduled form 8/15/11, 4/25/11 to 8/19/11 clinical notes from, 4/26/11 letter by Dr. PT eval report 5/4/11 from and Sports Medicine, 5/4/11 PT script, 4/28/11 PT script, 7/7/11 left knee

MRI report, 4/25/11 left knee radiographic reports, 8/25/11 denial letter and 9/22/11 denial letter.

Unimed Direct: 8/22/11 preauth request form. (all others were duplicative of those sent by Dr.)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

All records were reviewed and indicate an injury mechanism to the affected knee in July of 2010. The injured worker is a female who reports continued (primarily anterior) knee pain and intermittent popping of the knee. Exam findings were reviewed and included full knee motion with peri-patellar tenderness. A positive apprehension sign has been noted and she has an antalgic gait. Retropatellar crepitation was noted on 8/15/11. A 7/7/11 dated left knee MRI revealed only a trace effusion slight patellar edema and lateral tilt, along with mild cartilage thinning and medial meniscal wearing. Diagnoses have included patellar tendonitis and patello femoral syndrome. Bracing and NSAIDs and therapy have been tried and failed. "Team Rehab" therapy records were reviewed. Denial letter were reviewed and discussed the lack of diagnostic and/or therapeutic cortisone injection to the knee, along with the non-supportive diagnostic imaging. The 8/24/11 dated letter discussed that the AP, a Dr. felt that a cortisone injection would cause the knee to be in a worse condition.

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

The treating provider has fully assessed the diagnosis of patellofemoral syndrome. The condition has not resolved with comprehensive non-operative treatment. The utilization of cortisone is not guideline-required to establish the already documented condition. In addition, there is no significant contribution to pain generation from inflammation, hence the minimal knee effusion. The use of cortisone would therefore be unnecessary in an attempt to decrease such minimal inflammation and in fact could be deleterious. The MRI findings are at least "inconclusive" (and one of the ODG criteria for diagnostic arthroscopy) with cartilaginous thinning and meniscal degeneration which reasonably correlates with anterior knee pain and crepitus. The "joint pain", "effusion (albeit mild) and "crepitus" correlate with ODG criteria for arthroscopic chondroplasty or meniscectomy. The proposed procedures are therefore medically reasonable and necessary at this time, as per applicable clinical guidelines.

Reference: 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)

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

ODG Indications for Surgery-- Chondroplasty:

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).

ODG Indications for Surgery -- Meniscectomy:

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.

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)