

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/29/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient right knee scope chondroplasty of the medial femoral condyle 29877

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

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, chapter knee, chondroplasty
Peer reviews 07/13/11, 08/05/11
MRI right knee report 05/19/11
Dr. office notes 06/02/11, 06/27/11, 07/06/11, 08/10/11
Physical therapy note 06/09/11

PATIENT CLINICAL HISTORY SUMMARY

This is a female who felt her knee pop on xx/xx/xx. The MRI of the right knee from showed mild medial compartment and lateral compartment arthritis, mild patellofemoral arthritis, trace joint effusion and normal ligaments. There were no meniscal tears. Dr. evaluated the claimant on 06/02/11 for complaints of knee pain and locking. Dr. noted that the claimant had treated with a physician for an injection, which helped but caused swelling. The right knee x-rays that day showed no fracture, dislocation or arthritis. The examination revealed medial joint line tenderness and tenderness over the patella tendon and lateral patellofemoral joint. Physical therapy and NSAIDS were recommended. Dr. saw the claimant through 8/10/11. The claimant reported increased symptoms since last seen. McMurray was mildly positive. There was tenderness to the medial femoral condyle and to the medial patellar femoral joint. Range of motion was from 0 to 110 degrees. Dr. noted that the claimant had failed four months of physical therapy without improvement. Dr. recommended a right knee arthroscopic chondroplasty of the medial femoral condyle.

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

Outpatient right knee scope chondroplasty of the medial femoral condyle 29877 is not found to be medically necessary based on the records provided in this case. ODG indications for chondroplasty include failure of conservative care, continued joint pain and swelling, physical examination of findings of effusion, crepitation or limited range of motion and importantly a chondral defect by MRI. In this case, this claimant's MRI demonstrated medial and lateral

compartment arthritis, patellofemoral arthritis and no meniscal tears. There is no focal chondral defect by MRI. In general clinical practice, knee arthroscopy is not indicated to address knee arthritis. Therefore based on the standard of care and the Official Disability Guidelines, the reviewer finds that the previous adverse determinations should be upheld.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, chapter knee, chondroplasty

Criteria for chondroplasty (shaving or debridement of an articular surface)

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.
4. Imaging Clinical Findings: Chondral defect on MRI

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

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)