

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: September 6, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Knee Arthroscopy
Meniscal Debridement
Chondroplasty
Possible Lateral Release with Bursal Excision

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)
- Overtured (Disagree)**
- Partially Overtured (Agree in part/Disagree in part)

Right Knee Arthroscopy is medically necessary for treatment of the patient's medical condition.
Meniscal Debridement is medically necessary for treatment of the patient's medical condition.
Chondroplasty is medically necessary for treatment of the patient's medical condition.
Possible Lateral Release with Bursal Excision is medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 8/16/11.

2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/17/11.
3. Notice of Assignment of Independent Review Organization dated 8/17/11.
4. Medical records from Associates of dated 6/7/11, 7/5/11, and 7/26/11.
5. MRI of the right knee dated 4/8/11.
6. Letters from Attorney at Law dated 7/29/11 and 8/17/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an on-the-job injury to her right knee on xx/xx/xxxx during a fall. An MRI of the right knee was performed on 4/8/11. The impression was mild pre-patellar bursitis and small joint effusion. On 6/7/11, the patient's provider indicated the patient had sustained a contusion-type injury to the anterior aspect of the right knee. He noted the patient had been treated with physical therapy without relief and had undergone two cortisone injections without appreciable relief. On 7/26/11, the provider noted lateralization of the patella consistent with the patient's diagnosis. He assessed the patient with status post right knee anterior contusion injury with traumatic chondral injury patellofemoral articulation with crepitations, intermittent swelling and traumatic bursal formation, pre-patellar region, knee. McMurray's sign was positive and it is possible the patient has a medial meniscal tear not seen on MRI. The provider recommended surgical intervention, specifically, Right Knee Arthroscopy, Meniscal Debridement, Chondroplasty, and Possible Lateral Release with Bursal Excision.

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

Review of the submitted documentation demonstrates that this patient has attempted conservative treatment including physical therapy and injection therapy without adequate relief. With conservative care failing, knee surgery is in order as continued injections and/or physical therapy are not likely to be effective. Upon review of Official Disability Guidelines (ODG), I find that Right Knee Arthroscopy and Meniscal Debridement are medically indicated and necessary for this patient. ODG indications for Arthroscopy and Meniscectomy include conservative care, joint pain and swelling, positive McMurray's sign and limited range of motion. This patient meets these criteria. While evidence of meniscal tear was not noted on MRI, this can be confirmed during the scope. Given the patient's failure to respond to ongoing conservative treatment and continued signs and symptoms, Arthroscopy and Meniscal Debridement are medically necessary.

ODG indications for Chondroplasty include conservative care, joint pain and swelling, limited range of motion plus chondral defect on imaging. Based on the documentation provided, this patient has had an adequate trial of conservative care. In addition, she presents with joint pain, swelling, and limited range of motion. While MRI did not demonstrate a chondral defect, this can be confirmed once the surgeon is in the knee joint. Therefore, Chondroplasty is medically necessary for treatment of the patient's medical condition.

ODG indications for Possible Lateral Release with Bursal Excision include previous conservative care, knee pain and lateral tracking of the patella and abnormal patellar tilt on

radiographs. These criteria have been documented in the records provided. Therefore, the patient is an appropriate candidate for Possible Lateral Release with Bursal Excision and the procedure is medically necessary for treatment of her medical condition.

In conclusion, I have determined the following:

Right Knee Arthroscopy is medically necessary for treatment of the patient's medical condition.

Meniscal Debridement is medically necessary for treatment of the patient's medical condition.

Chondroplasty is medically necessary for treatment of the patient's medical condition.

Possible Lateral Release with Bursal Excision is medically necessary for treatment of the patient's medical condition.

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)