

Notice of Independent Review Decision

**[Date notice sent to all parties]:** August 14, 2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Left Knee Arthroscopy with Subchondral Drilling and Lateral Release

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

**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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Upon independent review, the reviewer finds the previous adverse determination should be overturned.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Records Received: 14 page fax 07/31/12 Texas Department of Insurance IRO request, 37 pages of documents received via fax on 08/03/12 URA response to disputed services including administrative and medical, 100 pages of documents received via USPS on 08/04/12 Provider response to disputed services including administrative and medical. Dates of documents range from 01/29/11 to 07/31/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained an injury at her place of employment while attempting to help a patient with a continuous passive motion device. This injury occurred on xx/xx/xx. The patient ultimately underwent a left knee arthroscopy on 02/28/11. Subsequent to the surgery, she continued to have symptoms and has had injections, including corticosteroids and hyaluronic injections and reportedly home physical therapy. At this point, she continues to have mechanical symptoms inclusive of pain, swelling, a positive apprehension sign, positive medial McMurray's sign, and crepitus with flexion and extension. Request is now for arthroscopic surgery with subchondral drilling and lateral release.

# The DYLL REVIEW

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## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

ODG guidelines, in my opinion, are clearly met. Previous reviews had indicated a lack of two months of physical therapy, and though records are not inclusive of physical therapy notes, there is mention of home physical therapy and a denial for supervised physical therapy. Additionally, the ODG guidelines indicate physical therapy or medications and do not rely on simply physical therapy alone as a qualifying feature.

The above review is based entirely on my review of the medical records available to me. I have not had the opportunity to either meet or examine this patient, nor have I had the opportunity to visually inspect any imaging or diagnostic studies. The information regarding diagnostic studies is purely that contained in printed medical record form.

### **ODG -TWC**

*ODG Treatment*

*Integrated Treatment/Disability Duration Guidelines*

### **Knee & Leg (Acute & Chronic)**

Microfracture surgery (subchondral drilling)

Recommended as indicated below for relatively small lesions. Microfracture surgery or subchondral drilling is an articular cartilage repair surgical technique, performed by arthroscopy, creating tiny fractures in the underlying bone causing new cartilage to develop. The emerging consensus favors osteoarticular allograft transplants (OATs) and microfracture techniques for relatively small lesions and ACI or osteochondral allografting for larger ones. ([Vasiliadis, 2010](#)) For articular cartilage injuries, ACI provides more durable results, but microfracture offers a faster recovery. ([Kon, 2011](#)) See also [Autologous cartilage implantation](#) (ACI).

### **ODG Indications for Surgery™ -- Microfracture surgery**

Procedure: Subchondral drilling or microfracture. Requires all 4 below:

1. Conservative Care: Medication OR Physical therapy (minimum of 2 months). PLUS
2. Subjective Clinical Findings: Joint pain AND Swelling. PLUS
3. Objective Clinical Findings: Small full thickness chondral defect on the weight bearing portion of the medial or lateral femoral condyle AND Knee is stable with intact, fully functional menisci and ligaments AND Normal knee alignment AND Normal joint space AND Ideal age 45 or younger. PLUS
4. Imaging Clinical Findings: Chondral defect on the weight-bearing portion of the medial or lateral femoral condyle on: MRI OR Arthroscopy. ([Washington, 2003](#))

Lateral retinacular release

Recommended as indicated below.

**ODG Indications for Surgery™ -- Lateral retinacular release:**

**Criteria** for lateral retinacular release or patella tendon realignment or maquet procedure:

- 1. Conservative Care:** Physical therapy (not required for acute patellar dislocation with associated intra-articular fracture). OR Medications. PLUS
- 2. Subjective Clinical Findings:** Knee pain with sitting. OR Pain with patellar/femoral movement. OR Recurrent dislocations. PLUS
- 3. Objective Clinical Findings:** Lateral tracking of the patella. OR Recurrent effusion. OR Patellar apprehension. OR Synovitis with or without crepitus. OR Increased Q angle >15 degrees. PLUS
- 4. Imaging Clinical Findings:** Abnormal patellar tilt on: x-ray, computed tomography (CT), or 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)