



MedHealth Review, Inc.  
661 E. Main Street  
Suite 200-305  
Midlothian, TX 76065  
Ph 972-921-9094  
Fax (972) 827-3707

## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 12/4/12

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s).

### **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 agrees with the previous adverse determination regarding the prospective medical necessity of arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s).

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

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed 4/22/11 letter, 10/26/12 denial letter, 10/29/12 appeal receipt letter, 11/5/12 denial letter, 10/26/12 report from, 10/31/12 report patient referral sheet 10/23/12, 9/11/12 to 10/23/12 notes 9/28/12 knee MRI report,

2/9/12 right knee MRI report, 10/9/12 electrodiagnostic report, 2/2/12 right knee MRI report, and 10/26/12 UR referral report.

all records were duplicative.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant has been considered for a second arthroscopic surgery of the right knee. The initial arthroscopic surgery was noted to have occurred in May, 2012. That was noted to have included an arthroscopic partial medial menisectomy performed by another provider. In particular, the 10-23-12 dated report discussed the recurrent right knee pain along with the claimant's right leg antalgic gait. Prior complaints had included "locking." as noted on 9-11-12. There was a mild effusion of the right knee with medial and lateral joint line tenderness. Range of motion was from 0-130°. Extreme flexion produced a degree of discomfort, as did the McMurray's test. The knee was stable to stress. Recent treatments were noted to include NSAIDs and a prescribed and self-administered home exercise program. The AP's patient declined a right knee cortisone injection. The 9-28-12 dated MRI of the right knee report discussed an effusion, degeneration of the menisci and chondromalacia patella. A 2-2-12 dated prior right knee MRI revealed a torn medial meniscus, along with degenerative changes of osteoarthritis. Denial letters discussed the lack of apparent recent comprehensive trial and failure of nonoperative treatments and the lack of indication of a torn meniscus on the recent MRI report.

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

Guideline criteria have not been met for a repeat arthroscopic surgical treatment in this knee. Imaging findings do not evidence a recurrent meniscal tear or other surgical indication, at this time. Applicable clinical guidelines only support such a request when there has been a recent trial and failure of comprehensive nonoperative treatments. In this case, there has not been such evidence provided. (A non-operative treatment protocol would typically include physical therapy and even visco-supplementation in this middle-aged patient with significant degenerative knee changes). There has also not been evidence of significant recurrent mechanical issues that would support intervention as requested. Therefore, the requested procedure is not medically necessary at this time.

Reference: ODG Knee Chapter. ODG Indications for Surgery- Menisectomy: Criteria for menisectomy 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.

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

**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)