

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: February 6, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right knee arthroscopy, synovectomy, lysis adhesions, and possible capsular release.

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)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

The requested services, right knee arthroscopy, synovectomy, lysis adhesions, and possible capsular release, are not 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 1/17/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 1/13/12.
3. Notice of Assignment of Independent Review Organization dated 1/17/12.
4. Notice of Determination from Coventry Workers' Comp Services dated 12/2/11 signed by MD.
5. Denial Letter from Workers Comp Services dated 12/30/11 signed by MD.
6. Diagnostic Center, Exam: MRI Knee Right with Contrast. Dated 3/9/11 performed by MD.
7. Diagnostic Center, Exam: Arthrogram Knee Right. Dated 3/9/11 performed by MD.
8. Orthopedic Clinic. Pre-Authorization dated 11/29/11 by Dr..
9. Diagnostic Center, Exam: MRI Knee Right with Contrast. Dated 11/18/11 performed by MD.
10. Diagnostic Center, Doctor's note dated 11/18/11 from MD.
11. Diagnostic Center, Exam: Arthrogram Knee Right dated 11/18/11 performed by MD.
12. Orthopedic Clinic, E&M Summary (1) Impressions dated 10/5/11.
13. Orthopedic Clinic, E&M Summary (2) Recommendations dated 10/5/11.
14. Knee/Leg/Thigh: Subjective, History.
15. Objective: Knee Exam.
16. Assessment, Preliminary Diagnoses (2) Knee.
17. Knee/Leg/Thigh: Analysis/Assessment of Surgical Conditions (part 1).
18. Probable and/or Possible Conditions based on History and Exam.
19. Knee/Leg/Thigh: Analysis/Assessment of Surgical Conditions (part 2).
20. Decision re: Procedure.
21. Knee/Leg/Thigh Plan/Recommendations/Treatment Summary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work injury to his right knee on xx/xx/xx when he fell from a step at work. Diagnoses have included right knee internal derangement and the patient was noted to be status post right knee surgery in April 2011. A right knee MRI performed on 3/9/11 noted chondrosis midline femoral trochlea with mild subchondral cystic change and mycoid degenerative change in the posterior horn of medial meniscus. On 10/5/11, it was noted that the patient had right knee pain, effusion/arthrofibrosis. The record indicated that conservative care had included medication and physical therapy. The patient was noted to be off work. An MR arthrogram was recommended for recurrent derangement and arthrofibrosis and a right knee arthroscopy was scheduled. An 11/18/11 right knee MRI showed a large amount of fibrous tissue appearing in the Hoffa's fat pad consistent with arthrofibrosis along with focal grade 4 chondrosis in the trochlear groove and stable chondrosis in the posterior aspect of the lateral tibial plateau.

Surgical intervention has been recommended, specifically, right knee arthroscopy, synovectomy, lysis adhesions, and possible capsular release. The Carrier indicates the requested services are

not medically necessary. According to the Carrier, second look arthroscopy is only recommended in cases of complications from OATS or ACI procedures to assess how the repair is healing or in individual cases that are ethically defensible for scientific reasons, only after a thorough and full informed consent procedure. The Carrier further states that the patient does not have documented significant deficits warranting the need for surgical treatment of his possible post-operative arthrofibrosis. Additionally, the Carrier maintains that conservative treatment options have not been documented or exhausted at this time.

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

The requested right knee arthroscopy, synovectomy, lysis of adhesions and possible capsular release are not medically necessary based on review of the submitted medical records. There is a 3/9/11 MRI of the right knee report that describes patellofemoral chondral changes as well as intact cruciate ligaments. While the 10/5/11 office visit with the patient's orthopedic surgeon describes the patient's complaints, it does not describe conservative treatment and does not document physical findings. Consistent with the Official Disability Guidelines, an arthroscopy scar resection and possible capsular release may be appropriate in patients who have subjective clinical/physical findings such as limited range of motion and postoperative scarring following previous surgery and failure of appropriate conservative care to include medications/injections or physical therapy. In this case, the treating physician has not documented conservative treatment to include therapy, exercises, possibly bracing or injection, and there are inadequate clinical findings documented in the medical records provided to support the procedure. Therefore, in light of the medical records which do not describe failure of appropriate conservative care or physical findings, the requested surgical intervention is not medically necessary.

Accordingly, I have determined the requested services, right knee arthroscopy, synovectomy, lysis of adhesions and possible capsular release, are not 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)