

SENT VIA EMAIL OR FAX ON
Mar/19/2012

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Knee Diagnostic Arthroscopy with Synovectomy and Lateral Gutter Debridement, Lateral Release, Patellar Femoral Chondroplasty, and Treatment as Indicated and Lysis of adhesions with or without manipulation, and purchase E0218 (continuous cryotherapy).

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

Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Request for IRO 02/27/12

Utilization review determination 01/24/12

Utilization review determination 02/14/12

Clinical records 09/13/11-12/08/11

Operative report 09/07/11

Physical therapy treatment records

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who has a date of injury of xx/xx/xx. The mechanism of injury is not described. The operative report indicates that the claimant has failed conservative measures and has evidence of a medial meniscus tear. On 09/07/11 the claimant was taken to surgery by at which time he underwent examination under anesthesia and diagnostic right knee arthroscopy partial medial meniscectomy limited synovectomy of the medial compartment medial femoral condyle chondroplasty. The claimant was seen in follow-up on 09/13/11. He's reported to be sore or achy with a bit of swelling he has no fever or constitutional symptoms his sutures were removed he has a moderate effusion no distal swelling negative Hellman's he's using crutches and limping pretty heavily intraoperative photo showing a meniscus tear was discussed unfortunately he is reported to have grade 4 chondral patellar chondromalacia as well as grade 2-3 chondromalacia in the other compartments he was

subsequently referred for physical therapy and provided the oral medication Celebrex the claimant was seen in follow-up on 10/17/11 he's reported to be doing well he has no further mechanical symptoms he is having some difficulty with persistent mild swelling and aching related to his chondromalacia he subsequently received an intraarticular or he underwent arthrocentesis with intraarticular injection of corticosteroids he was recommended to have additional physical therapy and was prescribed Lodine XL.

The claimant was seen in follow-up on 10/25/11. It's reported that the last corticosteroid injection did not help very much. He had additional swelling in therapy and this was discontinued he received a repeat corticosteroid injection at this visit.

The claimant was seen in follow-up on 11/15/11. He's reported to have continued problems with his right knee status post partial meniscectomy. It's reported that the second injection has helped quite a bit in general however he's still exquisitely tender over the superolateral portal. There's a palpable small nodule in this area underneath the edge of the lateralis fascia. He received an injection into the nodule at this visit. If he fails to improve he may require repeat arthroscopy to debride the nodule.

The claimant was seen in follow-up on 12/08/11. He's reported to have a lot of anterior knee pain markedly worsened by flexing his knee past 90 degrees. He further reports the knee is starting to lock and catch anteriorly on examination of the knee there are well healed portals there's no specific medial joint line tenderness negative McMurray's. He has complete loss of normal J-curve when compared to the other knee a very tight LPFL and lateral retinaculum the thick and boggy feeling on the lateral gutter may be consistent with post-operative adhesions subluxing of patella laterally markedly increases his medial symptoms deep knee flexion increases his symptoms. He's opined to have patellofemoral chondromalacia with a lateral maltracking adhesions with lateral gutter status post right knee surgery with increased maltracking. opines that this is post-operative complication that needs to be addressed surgically he has not made progress in therapy then recommends a right knee diagnostic arthroscopy synovectomy and lateral gutter debridement as well as lateral release.

The initial review of this request was performed on 01/24/12 by who non-certified the request noting that the patient is status post right knee partial medial meniscectomy on 09/07/11. He notes that the patient has participated in post-operative physical therapy but there's no comprehensive history of treatment including the total number of therapy visits modalities used and response to therapy. He notes that there are no post-operative diagnostic imaging studies submitted for the review with evidence of abnormal patellar tilt. He subsequently opines that medical necessity was not established.

Subsequent appeal request was reviewed on 02/14/12 by who non-supports the recommended surgery noting that the claimant is noted to have grade 4 changes to the kneecap at the time of operative intervention and that there is no clinical indication for role of lateral retinacular release in that there are no formal imaging supportive of abnormal tilt or indication for role of manipulation under anesthesia as the claimant obviously bends greater than 90 degrees. He subsequently notes that the proposed surgery in question cannot be supported based upon the above findings he therefore finds there's no clear indication for the cryotherapy.

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

The request for right knee diagnostic arthroscopy with synovectomy and lateral gutter debridement lateral release patellar femoral chondroplasty and treatment as indicated and lysis of adhesions with and without manipulation purchase E0218 continuous flow cryotherapy is not supported by the submitted clinical information and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant is status post a right knee partial medial meniscectomy limited synovectomy of medial compartment and medial femoral condyle chondroplasty on 09/07/11. The records indicate that the claimant has had continued complaints of pain with some swelling post-operatively and that the claimant has received at least two intraarticular corticosteroid injections and one

injection into a nodule. The record does not only contains limited physical therapy notes and does not provide detailed data regarding conservative management. Additionally it would be noted that there are no post-operative radiographic images or MRI establishing the presence of operative pathology. There is no supporting documentation in clinical record to establish the claimant has maltracking of patella. The claimant has greater than 90 degrees range of motion. There would be no indication for performance of manipulation under anesthesia. As a result, there would be no clinical indication for cryotherapy unit as medical necessity for requested surgical intervention has not been established.

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)