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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: April 30, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right knee arthroscopy medial meniscus repair.

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 right knee arthroscopy medial meniscus repair 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 4/17/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/17/12.
3. Notice of Assignment of Independent Review Organization dated 4/18/12.
4. Denial documentation.
5. Precertification request from MD dated 3/24/12.
6. Medical records from MD dated 1/05/12, 2/09/12, 2/23/12 and 3/15/12.
7. MRI of the right knee dated 12/07/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reportedly injured her right knee on xx/xx/xx. On 12/07/11, an MRI of the right knee revealed a small horizontal oblique tear of the posterior horn of the medial meniscus, intrameniscal degenerative signal versus a tiny grade 3 tear of the posterior horn of the lateral meniscus, grade 1 partial tear or sprain of the medial collateral ligament, and mild tricompartmental joint space narrowing and degenerative change. On 1/05/12, the medical records noted pain on the inside aspect of the right knee. It was noted that physical therapy had aggravated it. The examination showed medial joint line tenderness. There was no ligament instability, and the muscle mass was equal. X-rays showed some narrowing of the medial and lateral joint lines. On 2/09/12, continued right knee pain and swelling were reported. There was medial joint line tenderness and associated retropatellar pain in the front of the knee. She was noted to have failed conservative treatment, and a right knee arthroscopy and permanent restrictions were recommended. A steroid injection was given. The patient was reevaluated on 2/23/12, and examination revealed a suprapatellar effusion and medial joint line tenderness. On 3/15/12, the patient reported increased pain and swelling. She was noted to have failed physical therapy. The examination showed pain along the medial joint line and a suprapatellar effusion. The provider has recommended right knee arthroscopy medial meniscus repair.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested procedure. Specifically, the URA's initial denial stated that arthroscopic treatment for knees when symptoms are due to arthritic degenerative arrangements is not reasonably expected to be helpful. Per the URA, x-ray and MRI has demonstrated arthritis of her knee. The URA determined that it is not convincing from the medical records that the patient's symptoms are due to the meniscus tear rather than to the arthritis. On appeal, the URA noted that arthroscopic treatment of knees with degenerative changes but no evidence of a mechanical derangement has been shown to be ineffective treatment.

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

Official Disability Guidelines (ODG) criteria for surgery include conservative care, subjective clinical findings, objective clinical findings and imaging clinical findings. In this patient's case, she has failed physical therapy, injection, and medications, and her subjective clinical findings include knee pain. Objective clinical findings include a suprapatellar effusion, and MRI of the right knee revealed a small horizontal oblique tear of the posterior horn of the medial meniscus. On 12/07/11, the MRI report characterized the underlying arthritic changes as mild. Thus, the medical records do not demonstrate that the patient has severe arthritis that would contraindicate the requested surgical procedure. The requested surgery is medically indicated given the failure of conservative treatment and the patient's examination findings. Thus, the patient meets ODG criteria for the requested procedure, and the requested procedure is medically necessary for the treatment of this patient.

Therefore, I have determined the requested right knee arthroscopy medial meniscus repair 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 JUDGMENT, 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)