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**Notice of Independent Review Decision**

**DATE NOTICE SENT TO ALL PARTIES:** 11/5/12

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of outpatient left knee arthroscopy, arthrotomy, and chondroplasty.

**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 disagrees with the previous adverse determination regarding the prospective medical necessity of outpatient left knee arthroscopy, arthrotomy, and chondroplasty.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: xxx, Dr. XXXX, Dr. XXXX, and xxx xxx.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from xxx: 9/10/12 denial letter, 10/8/12 denial letter, 10/5/12 notice of adverse determination letter, 9/5/12 preauth request, 7/30/12 left knee MRI report, office notes 7/26/12 to 8/23/12, 9/28/12 appeal preauth request, 11/19/11 to 1/10/12 office notes, handwritten progress notes various DWC 73 forms, and 11/19/11 referral communication form.

Dr. XXXX: office notes by Dr. XXXX from 1/25/12 to 3/14/12, 3/6/12 CT scan report of right wrist, and 4/24/12 addendum to CT scan report.

Dr. XXXX all records were duplicative of other parties previously mentioned. xxx:

10/31/12 letter by xxx. xxx, 8/13/12 approval for right wrist CT, office notes 4/24/12 to 9/19/12/12, 8/17/12 right wrist CT report, 8/14/12 approval for right wrist CT, Anesthesia records 6/15/12 , 6/15/12 operative report, statement of pharm services 6/11/12, 5/15/12 ORIF scaphoid recommendation letter, 3/6/12 Hospital notes, PT notes 12/7/11 to 1/20/12, 11/19/11 to 1/23/12 office notes , 1/26/12 withdrawn preauth request letter, 1/19/11 tibia/fibula and wrist radiographic reports, and 1/6/12 PT preauth authorization.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The male fell off a ladder. He has had chronic knee pain (in addition to having undergone an ORIF for a navicular nonunion. The 7/30/12 dated left knee MRI revealed a chondral fissure and flap, along with tendinosis. AP records, including from 8/23/12 reveal ongoing knee pain and catching, along with tenderness at that site of catching. There was “good” range of knee motion. Treatment included NSAIDS and restricted activities. Denial letters noted the lack of evidence of non-operative treatments.

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

The injury mechanism, subjective (pain and catching) and objective (tenderness) findings correlate directly with the MRI abnormalities. There has been documentation of a trial and failure of reasonable non-operative treatment consistent with the clinical findings. The intent of applicable clinical guidelines support the consideration for diagnostic and therapeutic arthroscopy to establish a definitive diagnosis, chondroplasty to address the probable cartilage issues and arthrotomy to allow for visualization and treatment of the intra-articular issues. The request is reasonable and medically necessary as per guidelines.

Reference: ODG Knee Chapter

ODG Indications for Surgery -- Diagnostic arthroscopy:

Criteria for diagnostic arthroscopy:

1. Conservative Care: Medications. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS
3. Imaging Clinical Findings: Imaging is inconclusive.

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)**