

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

Date notice sent to all parties:

October 19, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal OP Right Knee Chondroplasty 29879 29876 29875 29881

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Chiropractic therapy note dated 02/22/12

MRI left shoulder dated 08/02/12

Letter of appeal dated 08/21/12

MRI of the knee dated 05/10/12

Clinical notes dated 05/17/12 – 09/13/12

Prior reviews dated 08/09/12 and 09/10/12

Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

- ❖ The patient is a female who sustained an injury on xx/xx/xx when she was struck in the medial knee by a child's head after the child tripped. The patient reported immediate swelling and pain within the right knee. MRI of the knee dated xx/xx/xx revealed increased signal within the anterior horn of the lateral meniscus. There were multiple cartilaginous defects in the lateral surface of the articular cartilage of the patella. Clinical evaluation on 05/17/12 indicated that the patient was utilizing medications to include Norco, Voltaren, and Flexeril. Physical examination revealed some loss of range of motion of the right knee to 130 degrees flexion. No instability was reported and there was pain with patellofemoral compression. The patient reported that increased weight bearing, walking, squatting, and flexion exacerbated pain. The patient was provided a brace and was referred for physical therapy and rehabilitation. Clinical note on 06/14/12 indicated that the patient was improving with physical therapy. The patient did complete physical therapy and utilized a home exercise program and brace at home. The patient was also utilizing Tylenol and Ibuprofen. Clinical evaluation on 09/13/12 stated that the patient continued to have constant pain in the right knee that was increased while climbing stairs. Physical examination revealed mild synovial swelling and mild loss of range of motion on flexion. Patellofemoral grinding was present and there was crepitus on range of motion. The clinical note indicates the patient did not respond to injections and was scheduled for a functional capacity evaluation. The request for right knee chondroplasty was denied by utilization review on 08/09/12. No opinion was provided. The request was again denied by utilization review on 09/10/12 as there was no clear documentation regarding effusion or crepitus.

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

The request for right knee chondroplasty is recommended as medically necessary based on the clinical documentation provided for review. The clinical documentation indicates that the patient had no long-term improvements with the use of physical therapy or medication management to include multiple anti-inflammatories and narcotics. The patient reported continuing joint pain that was made worse while climbing stairs. Physical examination did reveal fusion and crepitus with range of motion as well as loss of flexion. MRI studies from 05/12 clearly documented several cartilaginous defects in the right knee. As the clinical documentation provided for review does meet guideline recommendations for the request, medical necessity is established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

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

([Washington, 2003](#)) ([Hunt, 2002](#)) ([Janecki, 1998](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).