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**Notice of Independent Review Decision**

**DATE OF REVIEW:** NOVEMBER 8, 2013

**IRO CASE #:**

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

Patellofemoral articulation.  
Arthroscopy L knee shaving of acute chondral defect.

**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)

I have determined that the requested patellofemoral articulation is not medically necessary for treatment of the patient's medical condition.  
I have determined that the requested L knee shaving of acute chondral defect is not medically necessary for the 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 10/14/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) 10/16/13.
3. Notice of Case Assignment dated 10/17/13.
4. Imaging MRI Lower Extremity Joint – Knee dated 7/9/13.

5. Orthopedic Reevaluation and Progress Notes dated 10/8/13, 9/17/13, 8/20/13, 8/6/13, 7/23/13, 7/16/13, 7/10/13, 7/3/13, 6/28/13, and 6/25/13.
6. Denial documentation dated 9/13/13 and 8/12/13.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is male with derangement of the left knee joint, acute chondral defect, patellofemoral articulation, and aggravation of pre-existing osteoarthritis of the left knee joint. MRI of the knee dated 7/9/13 demonstrated grade 2-3 cartilage loss of the medial femoral condyle opposite medial meniscus posterior horn, cartilage degeneration of the medial patellar facet, and central trochlear without cartilage loss. On 6/25/13, the provider recommended operative arthroscopy and chondral shaving of the patellofemoral articulation. Clinical examination documents positive McMurray's test. The patient has requested authorization and coverage for patellofemoral articulation and arthroscopy L knee shaving of acute chondral defect.

The URA states the Official Disability Guidelines (ODG) criteria for chondroplasty include conservative care with medication or physical therapy, subjective clinical findings of joint pain and swelling, objective clinical findings of effusion, crepitus, or limited range of motion, and imaging clinical findings of chondral defect on MRI. The URA indicates there is a lack of documentation of extended conservative treatment as well as a lack of findings consistent with acute chondral defect of the patellofemoral articulation.

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

The requested services are not medically necessary for treatment of the patient's medical condition. The Official Disability Guidelines (ODG) indicate, "arthroscopic surgery for osteoarthritis, arthroscopic lavage and debridement in patients with osteoarthritis of the knee is no better than placebo surgery and arthroscopic surgery provides no additional benefit compared to optimized physical and medical therapies." The submitted clinical notes fail to document that the patient had exhausted conservative treatment for his left knee pain complaints to include evidence of exhaustion of supervised therapeutic interventions, anti-inflammatory drugs, injection therapy, and other conservative modalities. All told, the ODG do not recommend arthroscopic surgery for acute defect as no high quality studies exist supporting the requested operative procedures.

Therefore, I have determined that the requested patellofemoral articulation is not medically necessary for treatment of the patient's medical condition. In addition, the requested arthroscopy L knee shaving of acute chondral defect is not medically necessary for treatment of the patient's medical condition.

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**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)