

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right knee arthroscopy with abrasion chondroplasty

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Orthopedic Surgeon

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is this reviewer's opinion that the request for right knee arthroscopy with abrasion chondroplasty is not supported as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI right knee dated 11/20/12
Clinical notes dated 12/20/12 and 01/22/13
Prior reviews dated 01/14/13 and 02/12/13
Undated letter from the patient

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who has been followed for a history of right knee pain with associated locking. A MRI study of the right knee completed on xxxxxx revealed a horizontal nondisplaced tear within the posterior horn of the medial meniscus. Severe degenerative joint disease was present with loss of height in the joint spaces. Patellofemoral spurring was identified. Degeneration within the lateral meniscus was seen. Clinical evaluation on 12/20/12 reported continuing right knee pain despite 6 weeks of physical therapy. Physical examination revealed tenderness over the patellar facets and the poles of the patella. Tenderness to palpation over the medial and lateral joint line as well as the medial tibial plateau was also noted. There was tenderness over the quadriceps tendon and the lateral patellar retinaculum. The patient reported pain with range of motion of the right knee and crepitus was elicited. Positive McMurray's and Apley's compression tests were noted. The patient was assessed with a tear of the medial cartilage of the meniscus and the patient was recommended for a right knee arthroscopy with meniscectomy. Follow-up on 01/22/13 stated that the patient continued to have pain in the right knee with locking. The patient had been taking anti-inflammatories to include Motrin 3 times a day and reported no benefits from 3 months of physical therapy. Physical examination was unchanged from the prior evaluation.

The request for right knee arthroscopy with abrasion chondroplasty was denied by utilization review on 01/14/13 as no MRI study was submitted for review identifying a chondral defect.

The request was again denied by utilization review on 02/12/13; however, the prior reviewer's opinion was not submitted.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The request for right knee abrasion chondroplasty is not supported based on the clinical documentation provided for review. While the patient has imaging evidence of medial meniscal pathology as well as moderately severe degenerative joint arthritis in the right knee, the MRI studies did not identify a focal chondral defect with in the right knee that would reasonably require abrasion chondroplasty. The patient's objective findings are more consistent with a symptomatic meniscal tear and the patient was recommended for a right knee meniscectomy. Given that the requested procedures for chondroplasty are not indicated based on the MRI findings, it is this reviewer's opinion that the request for right knee arthroscopy with abrasion chondroplasty is not supported as medically necessary and the prior denials are upheld.

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)