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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Dec/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right Knee Arthroscopy with Lateral Release

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgeon (Joint)

REVIEW OUTCOME:

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

[X] 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 <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Legal correspondence 12/07/12
Request for IRO 12/06/12
Request for a review by IRO 12/07/12
Utilization review determination 11/05/12
Utilization review determination 12/03/12
Designated doctor evaluation 12/26/11
Clinical note Dr. XXXX 03/28/12
MRI right knee 05/08/12
Clinical records Dr. XXXX 08/03/12-11/20/12
Radiographic report 08/03/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant was reported to have sustained injuries to the bilateral knees. On this date, he tripped and fell, sustaining injuries in the presence of pre-existing degenerative disease.

Records indicated that the left knee pain resolved, however. He continued to have complaints of right knee pain that had not improved with conservative management. Treatment to date included oral medications and active and passive physical therapy. The claimant was seen by designated doctor who found compensable diagnosis to include a tear of the medial and lateral meniscus, sprain of the ACL and internal derangement of the knee. The claimant later participated in a work hardening program/work conditioning program. An MRI of the right knee was performed on 05/08/12 which noted advanced osteoarthritis in the patellofemoral joint with a large subchondral cyst. There was quadriceps tendinopathy at the pole of the patellar attachment and there was mild osteoarthritis of the medial and lateral joint space with subchondral cyst formation of the lateral tibial plateau. The claimant came under the care of Dr. XXXX on 08/03/12. At that time, the claimant received a diagnosis of chondromalacia patella of the right knee and a possible TFCC tear of the left wrist and the claimant received a corticosteroid injection into the right knee.

On 10/25/12, the claimant was seen in follow up by Dr. XXXX and continued to have right knee pain. He had complaints of popping, locking, and feelings of giveaway. Dr. XXXX reported that the claimant had exhausted physical therapy and oral medications and a cortisone injection and was recommended to undergo a right knee arthroscopy with lateral release to treat his chondromalacia patella.

The most recent clinical note was dated 11/20/12 and Dr. XXXX noted that the prior utilization review determination denied the procedure and reported that the claimant had exhausted an abundant course of non-operative treatment, including active and passive therapy and oral medications and corticosteroid injections. He reported that the claimant continued to have a highly positive patellar apprehension test and continued to experience a five degree extension lag with 110 degrees of flexion. The claimant had a negative McMurray and Lachman tests. There was crepitus audible upon flexion and extension. The claimant was recommended to undergo right knee arthroscopy with a lateral release.

The initial review was performed by Dr. XXXX on 11/05/12 who noted that based on the Official Disability Guidelines the role of the proposed surgery could not be supported. While the claimant was noted to have chondromalacia patella, he failed to meet Official Disability Guideline criteria for the role of the lateral retinacular to release and there was no evidence of imaging findings, or examination findings supportive of the need for a retinacular release and therefore the request was non-certified.

The appeal request was reviewed by Dr. XXXX on 12/03/12. Dr. non-certified the appeal request and found that while the claimant had exhausted conservative management, there was no data to support the performance of a lateral release and subsequently upheld the prior denial.

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

The request for right knee arthroscopy with lateral release is not supported as medically necessary and the prior utilization review determinations are upheld. The available clinical records indicate that the claimant initially sustained a contusion to his right knee as a result of a slip and fall. The records indicate that the claimant has undergone an extensive course of conservative treatment which has included oral medications and active and passive physical therapy and at least one corticosteroid injection and a work hardening conditioning program. The most recent clinical record provides objective findings of chondromalacia patella without evidence of patella mal-tracking which would require lateral release. Therefore, based on the clinical data provided, it is the opinion of this reviewer that the requested surgical procedure is not medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)