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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** December 16, 2012

**IRO CASE #:**

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

Arthroscopy/Partial Medial Meniscectomy Right Knee (29881 and 99235).

**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)

The requested Arthroscopy/Partial Medial Meniscectomy Right Knee is not medically necessary for 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 11/20/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/21/12.
3. Notice of Assignment of Independent Review Organization dated 11/26/12.
4. Denial documentation dated 11/7/12 and 10/29/12.
5. Group Pre-Authorization Request dated 11/2/12 and 10/24/12.
6. Group clinic notes dated 10/22/12.
7. MRI report dated 10/11/12.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury on xx/xx/xx. A magnetic resonance imaging (MRI) of the right knee dated 10/11/12 revealed findings of superficial edema overlying the patella, bone contusion of the inferior patella, and some medial compartment and lateral compartment arthritis as well as some patellofemoral arthritis. The patient also had extensive tearing of the posterior horn of the medial meniscus extending into the mid-body with a normal lateral meniscus. The patient was seen on 10/22/12, at which time the patient reported that he fell, injuring his right knee on 10/7/12. Physical examination revealed no effusion and no instability. The patient was recommended for surgical intervention consisting of right knee arthroscopy and partial medial meniscectomy.

The URA denied the requested surgery in a letter dated 10/29/12. The URA states that the request for surgery is denied as not medically necessary due to a lack of two months of conservative therapy and MRI findings. The request was again denied on 11/7/12.

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

The requested right knee arthroscopy and partial medial meniscectomy is not medically necessary for treatment of this patient's medical condition. The MRI study submitted for review indicated the patient had extensive tearing of the posterior horn of the medial meniscus extending into the mid-body. The clinical note submitted for review indicated the patient was recommended for surgery. However, the records do not contain a comprehensive physical examination or subjective complaints. There was no evidence of medial joint line tenderness, a positive McMurray's sign, or any subjective complaints to support the need for surgical intervention. There is also a lack of documentation of conservative care in accordance with Official Disability Guidelines (ODG) prior to surgical intervention. The ODG indications for meniscectomy include two symptoms and two signs to avoid scopes with lower yield (such as pain without other symptoms, posterior joint line tenderness that could just signify arthritis or an MRI with degenerative tear that is often false positive). Overall, the documentation submitted for review does not meet ODG criteria for the requested surgery consisting of arthroscopy and partial medial meniscectomy.

Therefore, I have determined the requested arthroscopy/partial medial meniscectomy of the right knee is not medically necessary for treatment of the patient's medical condition.

**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)