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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 1/5/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of right knee scope with LBR chondroplasty microfix. 29874, 29877, 29879.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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 reviewer disagrees with the previous adverse determination regarding the right knee scope with LBR chondroplasty microfix. 29874, 29877, 29879.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr. XXXX and TX Mutual.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr. XXXX: 12/6/12 follow up exam notes by Dr. XXXX, 10/3/12 initial exam notes by Dr. XXXX, 10/10/12 right knee CT scan report, and 10/10/12 right knee Arthrogram report.

TX Mutual: 12/19/12 letter by XXXX, provider listing page, 10/29/12 denial letter, 12/5/12 denial letter, 10/10/12 transcription coding report, 9/22/12 SOAP notes

from Clinic, and knee and leg ODG section with diagnostic arthroscopy, chondroplasty and microsurgery fracture pages.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The case involves a female who was noted to have diagnoses of right knee DJD and loose bodies. The mechanism of injury was noted to include a loading/twisting injury to the affected knee on the DOI.

On 12-06-12, the claimant was noted to have persistent pain, locking and catching of the knee, despite treatment with NSAIDS and a brace, along with restricted activities. Rightly motion was from -5 to 115°. There is tenderness along the medial aspect of the knee joint and medial femoral condyle, along with a positive McMurray sign. There was a mild effusion. 10-3-12 dated X-rays revealed mild degenerative joint disease medially. A CT-arthrogram dated 10-10-12 revealed loose bodies and chondral loss in the medial compartment and lateral trochlear groove. Surgical intervention was discussed. Denial letters discussed the lack of comprehensive nonoperative treatment and the lack of efficacy with regards to chondroplasty as a primary treatment for osteoarthritis. Additional denial rationale included the lack of complaints of swelling effusion or crepitus.

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

The claimant had significant pain and mechanical complaints that have affected activities of daily living. The persistent subjective complaints have been correlated with multiple positive abnormal examination findings including effusion, tenderness and positive McMurray's test. Diagnostic CT-Arthrogram revealed chondral irregularities and loose bodies. A reasonable amount of treatment has been tried and failed. Therefore, applicable ODG criteria have been met. Therefore, the procedures are medically reasonable and necessary at this time.

Reference: ODG Knee Chapter

ODG Indications for Loose body Removal:

Recommended where symptoms are noted consistent with a loose body, after failure of conservative treatment, but knee arthroscopic surgery for treatment of osteoarthritis is not recommended. In cases of knee osteoarthritis where mechanical symptoms are consistent with a loose body, meniscal tear or chondral flap tear, arthroscopy after failure of non-operative treatment is indicted. This is especially true if the pathology is in a compartment (i.e. lateral) other than one with advanced joint space collapse (i.e. medial). In order to fully address the mechanical symptoms if arthroscopy is chosen, all loose bodies, chondral flap tears and meniscal tears that could be causing the symptoms should be treated.

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

ODG Indications for Surgery- Microfracture surgery

Procedure: Subchondral drilling or microfracture. Requires all 4 below:

1. Conservative Care: Medication OR Physical therapy (minimum of 2 months). PLUS
2. Subjective Clinical Findings: Joint pain AND Swelling. PLUS
3. Objective Clinical Findings: Small full thickness chondral defect on the weight bearing portion of the medial or lateral femoral condyle AND Knee is stable with intact, fully functional menisci and ligaments AND Normal knee alignment AND Normal joint space AND Ideal age 45 or younger. PLUS
4. Imaging Clinical Findings: Chondral defect on the weight-bearing portion of the medial or lateral femoral condyle on: MRI OR Arthroscopy.

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 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)