

True Resolutions Inc.

An Independent Review Organization

500 E. 4th St., PMB 352

Austin, TX 78701

Phone: (214) 717-4260

Fax: (214) 276-1904

Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/08/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Right Knee Arthroscopy w/Microfracture

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:

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Notification of reconsideration determination 06/21/13

Notification of adverse determination 06/14/13

Office notes 02/20/13-06/11/13

MRI right knee 05/15/13

Maximum medical improvement and impairment rating 03/26/13

Physical therapy note 01/09/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who reportedly was injured on xx/xx/xx. Records indicated that he was pushing a cart when he felt a pop in his right knee. He was able to hang on to the cart and did not fall. The claimant was status post right knee arthroscopy on 12/17/12. Per office note dated 06/11/13 the claimant continued to have pain along the medial aspect of the knee. MRI of the right knee dated 05/15/13 revealed post-operative changes with meniscectomy involving the mid body and posterior horn of the medial meniscus extending to its root without recurrent tear identified. Moderate to severe osteoarthritic changes within the medial knee joint were noted which had significantly worsened since prior study in 2012. Stable mild to moderate osteoarthritic changes were identified primarily along the medial femoral condyle and medial femoral trochlea within the patellofemoral joint, unchanged over the interval. There was a grade 1 strain of the MCL; A small discoid lateral meniscus was stable without tear identified. Small joint effusion and Baker cysts were also noted. On physical examination the claimant was 70 inches tall and 227 pounds. Knee exam noted the claimant

ambulated on the right lower extremity with an antalgic gait. There was medial joint line tenderness. He had full active extension with flexion to 135 degrees. There was negative McMurray test. Arthroscopic portals were well healed without signs of infection.

A request for outpatient right knee arthroscopy with microfracture was reviewed on 06/14/13, and the request was non-certified as medically necessary. The reviewer noted that the case was discussed with a physician assistant who reported that the claimant had injections which were not included in the notes. The claimant reached maximum medical improvement as of 03/26/13 with a 1% whole person impairment rating. Repeat MRI on 03/15/13 documented no recurrent tear of the medial meniscus; moderate to severe osteoarthritic changes involving the medial compartment noted to have worsened since previous evaluation; degenerative joint disease also was noted with a discoid lateral meniscus. Physical examination findings documented the claimant to have moderate complaints of knee pain with tenderness to palpation along the medial joint line; full extension of the knee was noted with flexion to 135 degrees and negative McMurray test with well healed arthroscopy portals. Previous x-rays on 11/02/12 were mentioned and reportedly were negative for any significant findings. Consideration of corticosteroid injection was discussed, but the claimant desired surgical intervention. Based on treatment guidelines, microfracture surgical procedures were only indicated for individuals with a small full thickness chondral defect. The knee must also be fully stable with a fully functional menisci and ligaments. The claimant had already undergone a near total meniscectomy, and therefore did not meet qualifications for microfracture surgery. Also, no weight bearing x-rays were provided to document if there was any joint space narrowing. There must be weight bearing x-rays documenting normal joint spaces to proceed with microfracture surgery. The procedures were also only supported in individuals 45 years old or younger. The claimant had significant pre-existing degenerative joint disease, and at this time was not felt to be a proper candidate for a microfracture surgery. It was further noted that lower levels of care such as corticosteroid injections had not been attempted and therefore the request could not be certified.

A reconsideration request for outpatient right knee arthroscopy with microfracture was reviewed on 06/21/13, and the request was non-certified as medically necessary. The reviewer noted that the documentation submitted for review evidenced the claimant continued to present with right knee pain complaints status post work related injury in xx/xx and subsequent surgical intervention in 12/12 with arthroscopic partial medial meniscectomy and chondroplasty procedures. It was further noted that the claimant had completed nine sessions of post-operative physical therapy. The reviewer noted that the current request previously received an adverse determination due to a lack of documentation of efficacy of corticosteroid injection to the knee of the claimant in addition to the claimant not meeting criteria for microfracture surgery. The reviewer noted that the claimant presented with no objective functional deficits upon physical examination, the clinical notes did not evidence any weight bearing imaging studies of the knee, and the claimant had only utilized nine sessions of post-operative physical therapy; therefore, the current request was not supported. Guidelines indicated conservative care physical therapy times a minimum of two months.

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

The claimant sustained an injury to the right knee and underwent right knee arthroscopy with near total medial meniscectomy and chondroplasty on 12/17/12. The claimant continued to complain of pain along the medial aspect of the right knee. Repeat MRI of the right knee was obtained on 05/15/13 which revealed post-operative changes with no evidence of recurrent medial meniscal tear and moderate to severe osteoarthritic changes within the medial knee joint which have significantly worsened in the interval since previous study on 11/14/12. As noted on previous reviews, no weight bearing radiographs of the knee were documented with evidence of or with evaluation of any joint space narrowing. It was noted that a previous corticosteroid injection was performed to the knee, but no assessment of the response to this procedure was documented. It was also noted that the proposed surgical procedure is recommended in patients that are 45 years old or younger. Based on the clinical information

provided, it is the opinion of this reviewer that the requested outpatient right knee arthroscopy with microfracture does not meet Official Disability Guidelines criteria, and the surgical procedure is not indicated as 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

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)