

# Independent Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

May/27/2014

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient right knee chondroplasty, medial femoral condyle (MFC), microfracture MFC

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

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.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

#### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her right knee on xx/xx/xx when she had a slip and fall on a marble floor. A clinical note dated 03/06/14 indicated the patient having previous surgery on the right knee and had been doing well. However the patient reported pain and swelling at the knee after the fall. Pain radiated into the anterior aspect of the tibia. The patient utilized ice and a walking cane. Upon exam tenderness to palpation was identified over the anterior aspect of the knee and medial joint line. The patient had positive McMurray sign. Swelling was minimal. X-rays of the right knee revealed a lateral tracking patella and mild narrowing of the lateral facet. Mild medial joint line narrowing was identified. MRI of the right knee dated 03/13/14 revealed ACL and PCL degeneration. Medial femoral condyle fracture with subchondral cystic changes and diffuse bone edema was also identified. Progressive medial compartment chondromalacia was revealed. A clinical note dated 03/24/14 indicated the patient continuing with right knee pain. The patient was ambulating with a cane. Pain was identified over the medial aspect of the right knee. The patient was recommended for arthroscopic chondroplasty at this time. A clinical note dated 03/28/14 indicated the patient having a BMI of 43. A clinical note dated 04/28/14 indicated the patient continuing with right knee pain. The patient continued to be recommended for surgical intervention. Utilization reviews dated 04/03/14 and 04/14/14 resulted in denials as no information was submitted confirming completion of any conservative treatment.

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

The clinical documentation indicates the patient complaining of right knee pain after a slip and fall. A chondroplasty would be indicated provided that the patient meets specific criteria, including imaging studies confirming pathology and completion of all conservative treatment. There is an MRI confirming chondromalacia findings. However, no information was submitted regarding previous involvement with therapeutic interventions addressing right knee complaints. Given this, the request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for Outpatient right knee chondroplasty medial femoral condyle and microfracture is not recommended 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)