

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/04/2014

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** right knee arthroscopy, meniscus, retropatellar decompression, chondroplasty

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of this reviewer that the request for a right knee meniscectomy with a retropatellar decompression, and chondroplasty is not indicated as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who reported an injury to her right knee when she had been squatting on xx/xx/xx and felt a loud pop. The MRI of the right knee dated 09/10/14 revealed no evidence of internal derangement. A slight lateral patellar subluxation was identified without dislocation. Small knee effusion was identified without any loose bodies. Mild degenerative findings were identified within the posterior horn of the medial meniscus without a tear. The clinical note dated 09/22/14 indicates the patient complaining of 6/10 pain at the right knee. Pain was exacerbated with weight bearing activities. The therapy note dated 10/13/14 indicates the patient complaining of right knee pain primarily at the anterior region. The note does indicate the patient having undergone a steroid injection and was wearing a hinged knee brace. The patient has also been utilizing Norco and Mobic for pain relief. The clinical note dated 10/24/14 indicates the patient complaining of significant pain with range of motion limitations. The patient had previously undergone 7 physical therapy sessions to date. The patient was being recommended for a right knee meniscectomy, retropatellar decompression, and chondroplasty.

The utilization review dated 10/15/14 resulted in a denial as insufficient information had been submitted confirming a meniscal tear by imaging studies. The utilization review dated 10/20/14 also resulted in a denial as the submitted imaging studies revealed essentially benign findings.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient complaining of right knee pain. A meniscectomy and chondroplasty are indicated for patients who have significant findings confirmed by imaging studies. The submitted MRI revealed essentially normal findings at the knee with no significant findings that would likely benefit from the surgical intervention. Without confirmatory evidence in place the request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for a right knee meniscectomy with a retropatellar decompression, and chondroplasty is not indicated as medically necessary and the prior denials are upheld.

**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)