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Notice of Independent Review Decision

Case Number:

Date of Notice: 07/13/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Right knee arthroscopic partial medial menisectomy, chondroplasty and synovectomy

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)

Patient Clinical History (Summary)

The patient is a male who was injured on xx/xx/xx while walking down steps. The patient developed complaints of right knee pain. The patient was initially seen on 01/28/15 for complaints of right knee pain 8/10 in intensity. The patient initially utilized ice and heat as well as over the counter medications for pain. Initial radiographs reported no fracture or dislocation. The patient was referred for physical therapy. Other medications to date include the use of valium for musculoskeletal pain. The patient was also prescribed anti-inflammatories such as naproxen. Despite this treatment the patient continued to report pain and swelling in the right knee. MRI studies of the right knee completed on 03/22/15 noted some marginal spurring of the articular cartilage consistent with mild osteoarthritis. The patellofemoral compartment was obscured. There was thinning of the ACL with a possible chronic partial thickness tear. There was a mildly complex tear involving the posterior horn of the medial meniscus. The patient was evaluated by on 04/20/15 for persistent complaints of right knee pain despite medications including anti-inflammatories. The patient's physical examination noted a positive medial McMurray's sign with medial joint line tenderness involving the right knee. There was a follow up with on 04/22/15 which also noted continuing right knee pain. The patient's physical examination again noted tenderness over the medial and lateral joint lines of the left or right knee with positive anterior drawer sign with no laxity or translation. There was some limited range of motion on flexion of the right knee but extension was normal. Due to failure of conservative treatment the patient was recommended for a surgical intervention. The surgical request for right knee meniscectomy and chondroplasty was denied on 05/14/15 as there was no specific indications of failure of conservative treatment to include physical therapy or medications. There was also no evidence of chondral defect on MRI. The request was again denied on 06/09/15 as it was still unclear whether the patient had had any formal physical therapy injections or other exercise programs. There was no evidence of mechanical locking or range of motion.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The clinical records provided for review did note physical examination findings consistent with a symptomatic meniscal tear. There was evidence of medial joint line tenderness with positive McMurray sign. The patient's range of motion was restricted to 105 degrees flexion. The patient's MRI studies noted a complex medial

meniscal tear which would correlate with the patient's symptoms. The patient is noted to be obese but is also fairly young at x. Per Official Disability Guidelines recommendations for younger patients who are active arthroscopy is recommended without physical therapy. In this case there is no locking or blocking of the left knee or right knee. It is unclear what patient's actives it is also unclear what the patient's activities are. Given the patient's obesity and lack of documentation regarding failure of conservative treatment, it is this reviewer's opinion that the proposed surgical procedures would not be considered medically necessary under Official Disability Guidelines recommendations. MRI studies also found no evidence of chondral defects on MRI that would support chondroplasty procedures requested. Therefore the prior denials remain upheld at this time.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ 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 and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)