

# Clear Resolutions Inc.

An Independent Review Organization  
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**DATE NOTICE SENT TO ALL PARTIES:** Mar/29/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Right knee arthroscopy, debridement with Osteochondral Allograft

**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 arthroscopy, debridement with Osteochondral Allograft is not medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female. On xx/xx/xx, the patient was taken surgery for a right knee internal derangement and procedure performed included a subtotal lateral meniscectomy, chondroplasty of the patella and the medial femoral condyle with tricompartmental sign of ectopy. On xx/xx/xx, the patient returned to clinic with complaints of right knee pain with no improvement in pain. Previously she had a right knee arthroscopy, steroid injections, Synvisc supplementation and physical therapy little to no improvement. A diagnostic arthroscopy with a possibility of an OATS procedure for the medial femoral condyle chondral defect was discussed. On exam, there was tenderness to palpation about the femoral condyle on the medial aspect, and with weight bearing with knee flexion at approximately 30 degrees.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** On XX/XX/XX, a utilization review report stated the request for arthroscopy of the right knee with harvesting of the osteochondral autograft, was not supported as being medically necessary as there was a lack of recent diagnostic imaging and physical examination findings supporting substantial pathology, and or warranting the medical necessity for additional surgery.

On XX/XX/XX, a utilization review report stated the request for a right knee arthroscopy was non-certified, as there was a lack of recent pathology on imaging to support the request.

The records indicate the patient was taken surgery but after that surgery, no further imaging was provided to document additional pathology not addressed by that surgery. The guidelines state that there should be positive findings on imaging to warrant this procedure.

It is the opinion of this reviewer that the request for a Right knee arthroscopy, debridement with Osteochondral Allograft is not 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)**