

# INDEPENDENT REVIEWERS OF TEXAS, INC.

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**[Date notice sent to all parties]:**

**05/04/216**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** arthroscopic partial medial meniscectomy

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

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is an individual. On XX/XX/XX, an MRI of the left knee revealed fraying of the free edge margin of the posterior horn of the meniscus with some superficial irregularity along the anterior articular surface. There was a mild free edge truncation of the medial meniscus body; the lateral meniscus was intact. On XX/XX/XX, the patient was seen in clinic. The examination of the left knee revealed an effusion and marked pain and tenderness to the medial joint line. There was a positive Apley's and McMurray's. The patient lacked 5 degrees of extension and had 130 degrees of flexion. The ligaments were stable. It was noted the MRI showed a moderate joint effusion with a tear of the medial meniscus and the recommendation was to begin physical therapy, and an arthroscopic partial medial meniscectomy was also recommended.

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

On XX/XX/XX, a utilization review request for the left knee arthroscopic partial medial meniscectomy as an outpatient, was reviewed, and Official Disability

Guidelines knee chapter was utilized. It was noted that there was no particular conservative instrument interventions that had been attempted such as physical therapy or steroid injection, and there was no clear clinical indication for arthroscopic surgery. The request was non-certified.

On XX/XX/XX, a utilization review request for the reconsideration for the left knee arthroscopic partial medial meniscectomy as an outpatient, also utilized Official Disability Guidelines knee and leg chapter, and stated that there was no definitive tear identified on MRI, but rather degeneration of the menial medial meniscus. Furthermore, the injured employee had not completed conservative treatment to include any physical therapy or home exercise. Therefore the request was non-certified.

The guidelines state that there should be definite evidence of a meniscal tear on MRI. Unless the knee is locked or blocked, there should be attempts at conservative care. The records do not indicate the knee is knocked or blocked at this time, and there is a paucity of information regarding conservative care. The MRI also fails to reveal a meniscal tear that would be amenable to arthroscopic surgery.

It is the opinion of this reviewer that the request for left knee arthroscopic partial medial meniscectomy as an outpatient 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:**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**