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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** January 8, 2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Left knee diagnostic arthroscopy.

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

M.D., Board Certified in 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)

I have determined that the requested left knee diagnostic arthroscopy is medically necessary for the treatment of the patient's medical condition.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient is a male who sustained an industrial injury on XX/XX/XX. He underwent left knee arthroscopy with partial medial meniscectomy and chondroplasty on XX/XX/XX. On XX/XX/XX, the medical records noted that the patient initially felt better after surgery, but the left medial knee pain had returned and there was onset of lateral pain as well. The patient reported painful grinding and popping. He needed to climb into a truck, and this was currently very difficult. He reported swelling of the entire knee and was wearing a hinged knee brace for support. He had difficulty fully extending the knee. He had not attended physical therapy in a long time but was continuing to perform home exercises. The patient had been taking ibuprofen

but had discontinued due to concern regarding side effects. Left knee exam documented tenderness to palpation over the medial joint line with guarding, active extension lacked 15 degrees with guarding, and passive extension was full. There was no instability. A corticosteroid injection was provided. On XX/XX/XX, the records noted left medial knee pain and functional difficulty going up and down stairs. Left knee exam documented tenderness to palpation over the medial tibiofemoral compartment and patellofemoral crepitus. A request has been submitted for left knee diagnostic arthroscopy.

The URA has denied coverage for the requested services. The URA's initial denial noted that assessment indicated mechanical symptoms, but the record provided for review did not document current subjective complaints of a mechanical nature. On appeal, the URA noted that arthroscopic surgery will give no lasting benefit and is not medically necessary.

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

The Official Disability Guidelines (ODG) generally do not recommend arthroscopic surgery for osteoarthritis. Guidelines state that arthroscopic lavage and debridement in patients with osteoarthritis of the knee is no better than placebo surgery, and arthroscopic surgery provides no additional benefit compared to optimized physical and medical therapy. Guidelines state that arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless a patient has a clear history of mechanical locking associated with intra-articular loose bodies or meniscal tears. The ODG recommend diagnostic arthroscopy when assessment of cartilage is crucial for a definitive decision regarding therapeutic options in patients with osteoarthritis. Surgical criteria include medications or physical therapy, plus pain and functional limitations despite conservative care, and inconclusive imaging. Per ODG, the requested services are medically necessary. This patient presents with persistent left knee pain with mechanical symptoms. Functional difficulty limits his ability to perform essential job tasks. Clinical examination findings are consistent with reported imaging evidence of chondral pathology, and evaluation of chondral surfaces was planned. Detailed evidence of a recent, reasonable and/or comprehensive nonoperative treatment protocol trial and failure has been submitted. Therefore, the requested left knee diagnostic arthroscopy is medically indicated for the treatment of this patient.

Therefore, I have determined the requested left knee diagnostic arthroscopy is medically necessary for treatment of the patient's medical condition.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN 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 JUDGMENT, 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)