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DATE OF REVIEW: 5/29/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Left knee Arthroscopy; Partial Meniscectomy and Synovectomy, CPT 29881, 29876

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Orthopedic Surgery

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

Upheld	**(Agree)**	**X**
Overturned	(Disagree)	
Partially Overturned	(Agree in part/Disagree in part)	

PATIENT CLINICAL HISTORY SUMMARY
A XXXX injured left knee while XXXX onto the left knee. XXXX experienced immediate onset of pain. XXXX presented to XXXX on XXXX with moderate left medial left joint pain, described as sharp. The initial physical exam showed left knee swelling, a left limp, medial joint line tenderness, restricted left knee flexion in extension, and positive medial McMurray test. Outside x-rays report, not reviewed by this reviewer, showing no fracture, normal alignment, no bony lesions, normal soft tissues, and normal joint spaces.

MRI of the left knee performed without contrast XXXX shows equivocal findings for small, nondisplaced horizontal undersurface tear peripheral posterior horn medial meniscus. Normal lateral meniscus, normal ligaments, normal osseous structures and articular cartilage. XXXX was noted to have local edema in the superalateral aspect of Hoffa's fat pad reflecting mild impingement. No effusion noted. There is no muscle edema or atrophy. Impression was mild patellofemoral impingement and equivocal findings for a tiny nondisplaced oblique horizontal undersurface tear at the peripheral posterior horn medial meniscus on one image.

Patient was treated with physical therapy and anti-inflammatories.

Follow-up visit with XXXX showed the patient has weakness, giving away, feelings of instability; no improvement of left medial joint pain; no improvement with physical therapy. Patient is still on crutches. I saw no mention of XXXX work status. XXXX recommended surgery.

Follow-up visit with XXXX on XXXX reports patient having sharp pain with catching and locking, symptoms unchanged.

Physical examination showed medial joint line tenderness, full range of motion, positive McMurray test, but no mention of swelling. Once again, therapy and surgery were recommended.

Follow-up visit with XXXX on XXXX notes patient using crutches, no improvement with physical

therapy, continued left anterior and left medial joint line pain, symptoms unchanged. Physical examination shows diffuse anterior and medial joint line tenderness, full range of motion, normal strength, positive McMurray test, and a positive limp. Once again, surgery was recommended.

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

Opinion: I agree with the benefit company's decision to deny the requested service(s).
Rationale: I believe the MRI findings are equivocal for significant meniscus tear. Patient appears to have undergone appropriate evaluation, treatment with anti-inflammatories, modification of activities, and physical therapy. I would recommend a trial intra articular XX, with or without cortisone, to verify that XXXX pain is, indeed, from an intra articular source. This could also give XXXX some relief of pain. **The requested left knee arthroscopy: Partial Meniscectomy and Synovectomy (CPT 29881, 29876) is not medically necessary. (amended)**

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE
AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X
MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
MILLIMAN CARE GUIDELINES
ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X
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 DESCRIPTION)
OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)