Medical Assessments, Inc.

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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
1 right knee arthroscopy with partial medial meniscectomy between XX and XX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Orthopedic Surgeon with over 15 years of experience.

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 claimant is a XX reported an occupational accident on XX while moving in XX with a XX that was in the way. XX tried pushing the stand with XX foot and experienced knee pain.

XX: 3-X-rays view of knee by XX, MD. Impression: No fracture of other acute finding identified.

XX: MRI knee without contrast right interpreted by XX MD. Impression: Consistent with slightly depressed medial tibia plateau fracture and surrounding edema for which plain film correlation was recommended, associated tear the posterior horn of the medial meniscus and grade 1 sprain of the medial collateral ligament.

XX: Progress notes by XX, MD. Claimant reported knee pain and initially continued work but ultimately pain interfering with work and daily life. Treated with XX. Clamant wants to proceed with surgery.

XX: Follow up progress notes by XX, MD. Claimant has full ROM and trace effusion and very tender medial joint line and pain medially with McMurray testing. Nontender proximal tibia, stable ligamentous exam. Diagnosis: Complex tear the medial meniscus of the right knee. Provided treatment with injections.

XX: Follow up progress notes by XX, MD. Claimant was fully examined and recommending surgery.

XX: UR performed by XX, MD. Rationale for denial: The claimant is a XX who sustained a knee injury on XX. The provider is requesting right knee arthroscopy with partial medial meniscectomy. The requested medical treatment listed does not meet medial necessity, based on the information submitted.

XX : UR performed by XX, MD. Rationale for denial: The claimant is a XX being treated for nondramatic right knee pain that XX reported an association with an incident at work about XX ago. XX has been treated with medications and injection and activity modifications but no report of exercise therapy. XX has persistent symptoms interfering with activities and tenderness of the medial joint line of XX right knee with pain in response to McMurray test. XX has full ROM. XX has diagnostic imaging demonstration of a meniscus tear as well as arthritic change. Particularly in the medial compartment of the knee, including joint space cartilage loss osteophytes. Concerns that there is no reported contraindication such as a block to motion, to participation in a trial of rehab exercise. The request is recommended to be not certified.

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

The request for right knee arthroscopy with partial meniscectomy is denied.

This patient is a XX who sustained a work injury on XX. A medial meniscal tear was identified in the XX MRI of the knee. No significant arthritic changes were noted on this study. XX has been treated with medication, injection and activity modification. XX continues to have medial sided knee pain and has a positive McMurray's sign on examination. The treating physician has recommended knee arthroscopy to address the medial meniscal tear. XX office notes indicate arthritic changes on plain films, which may also be a source of medial sided knee pain.

The Official Disability Guidelines (ODG) supports partial meniscectomy in patients who have failed conservative care, who have objective and subjective findings consistent with a meniscal tear identified on MRI. Conservative care includes physical therapy and/or home therapy, as well as medications.

There is no documentation of physical therapy for this patient. XX cannot be considered for surgery without a course of physical therapy first.

The request for 1 right knee arthroscopy with partial medial meniscectomy between XX and XX.
is found to be not medically necessary.

ODG Guidelines:

ODG Indications for Surgery™ -- Meniscectomy:

Criteria for meniscectomy or meniscus repair (It is recommended to require 2 symptoms and 2 signs to avoid arthroscopy with lower yield, e.g., pain without other symptoms, posterior joint line tenderness that could signify arthritis, or MRI with degenerative tear, which is often a false positive). Physiologically younger and more active patients with traumatic injuries and mechanical symptoms (locking, blocking, catching, etc.) should undergo arthroscopy without PT.

1. Conservative Care: (Not required for locked/blocked knee.) Exercise/Physical therapy (supervised PT and/or home rehab exercises, if compliance is adequate). AND (Medication. OR Activity modification [e.g., crutches and/or immobilizer].) PLUS

2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of giving way. OR Locking, clicking, or popping. PLUS

3. Objective Clinical Findings (at least two): Positive McMurray's sign. OR Joint line tenderness. OR Effusion. OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS

4. Imaging Clinical Findings: (Not required for locked/blocked knee.) Meniscal tear on MRI (order MRI only when above criteria are met). (Washington, 2003)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

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 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)**