

IRO NOTICE OF DECISION – WC

IRO REVIEWER REPORT - WC

DATE OF REVIEW: 04-13-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Denial of preauthorization approval for left knee arthroscopy with partial medial meniscectomy

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

Certified by the American Board of Orthopaedic Surgery
General Certificate in Orthopaedic 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 or not medical necessity exists for each of the health care services in dispute.

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld Overturn
		Prospective	836.0	29881	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notices of Preauthorization Denial and Rationale (03-07-07 and 03-26-07)
MRI, extremity lower joint (02-05-07)
Physician Examination Note (02-27-07)

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient fell in a hole while at work and injured his knee.
02/05/07-MRI left knee without contrast: No evidence of bone edema. No clear evidence of meniscus tear. Some signal noted in posterior horn or medial meniscus-may be related to trauma. Collateral ligaments & ACL intact.
02/27/07-The examination noted minimal pain in the anterior and medially and a little discomfort in the posterior knee. Immobilizer has not been used. Denies locking but has some pain medially with pivoting. Full range of motion hips & knees. No ligamentous laxity. Exam: medial joint line tenderness left knee. Knee x-rays negative. Current medications include hydrocodone and Tramadol Hydrochloride.

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

Medical necessity for the requested surgery has not been met. The Reviewer noted that the record does not document trial of non-operative measures (e.g., physical therapy, activity/job modifications). The Reviewer also noted that this patient had no evidence of bone bruise, minimal pain, questionable McMurray's test, no locking, no giving way, no history of recurrent effusions, and no mechanical signs.

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)**