

P-IRO Inc.

An Independent Review Organization
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DATE OF REVIEW: July 24, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient right knee arthroscopy

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

Board Certified Orthopedic Surgeon

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office notes, Dr. 05/08/07 and 06/08/07
Request for dispute resolution, 07/06/07
Denial Letters from URA (5/24/07 and 6/18/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male with a left knee injury with MRI evidence of a medial meniscus tear. He had an injury to the right knee when he stepped in a hole.

On 05/08/07 Dr. evaluated the claimant. He noted that the claimant had an injury to the left knee and stepped in a hole and injured his right knee. He had not worked in a couple

of months due to bilateral knee pain. On examination there was full motion and the knees were stable. Dr. noted that the 04/11/07 MRI of the right knee showed a medical meniscus tear and did the 2006 MRI of the left knee without other significant abnormalities. X-rays were unremarkable. Arthroscopy was first recommended for the bilateral knees but when he returned on 06/08/07 the left knee was much improved. A request was made still for arthroscopy of the right knee.

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

The claimant is a male for whom request has been made to undergo right knee arthroscopy. Information in the records suggests that this gentleman has had ongoing bilateral knee complaints following an injury. Reportedly an MRI scan shows evidence of a torn medial meniscus. X-rays reportedly describe no evidence of degenerative change.

The Reviewer cannot recommend the proposed arthroscopic surgery as being reasonable and medically necessary as the records do not reflect that conservative treatment has been exhausted. While it appears that there has been sufficient time elapsed and that conservative treatment may well have been undertaken, the records themselves do not document treatment such as an exercise program, corticosteroid injection, activity modification, and/or anti-inflammatories. Therefore, the claimant would not meet the ODG criteria for operative arthroscopy.

Official disability Guidelines Treatment in Worker's Comp 2007 Updates-Knee
ODG Indications for Surgery™ -- Meniscectomy:

Criteria for meniscectomy or meniscus repair:

1. Conservative Care: (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. PLUS
2. Subjective Clinical Findings: Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS
3. Objective Clinical Findings: 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.

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)**