

# IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 817-549-0310

**DATE OF REVIEW:** JULY 20, 2007

**IRO CASE #:**

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

Left knee scope

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

MD 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**

Case Assignment from TDI 7/6/07

Knee three view 04/17/07

Office note of Dr. 04/25/07, 05/16/07, 07/09/07

MRI left knee 05/04/07

Peer review 05/30/07, 06/21/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a obese female who was kneeling down on xx/xx/xx and felt pressure to her left knee. There was no previous injury reported. The claimant saw Dr. on 04/25/07. The claimant reported continued pain with effusion, occasional popping especially with stairs

and steps. She was taking Aleve without relief. Exam findings revealed a 2 plus effusion, tenderness to the medial joint and a tender McMurray. Plain films, date not provided, from Hospital were unremarkable. Diagnosis was late effect of a left knee sprain with suspected medial meniscus tear. A MRI of the left knee was recommended and performed on 05/04/07 which showed a medium to large size joint effusion, mild degenerative changes of the menisci and a possible tear in the posterior horn of the medial meniscus. There was very mild chondromalacia of the patella. There was no evidence of a ligament or tendon injury.

Dr. saw the claimant on 05/16/07 for persistent left knee pain, popping, and swelling with limping. Dr. felt that the MRI showed degenerative type medial meniscus tear and large effusion. Dr. noted that the claimant had been on multiple conservative treatments including anti-inflammatories and rest for no benefit. Exam findings revealed range of motion of 5 to 120 degrees, exquisite tenderness with full extension in the medial joint, and 2 plus knee effusion. There was tenderness to the medial joint. Diagnosis was subacute left knee sprain with clinical and imaging evidence of medial meniscus tear, left knee. Dr. recommended arthroscopic surgery including probable partial medial meniscectomy. The claimant was evaluated by Dr. on 07/09/07. Dr. felt that physical therapy was not indicated due to normal range of motion, normal muscle control of the thigh and calf. Dr. noted that the claimant was not using an ambulatory device.

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

This claimant has positive physical exam findings with limited range of motion. The MRI is positive. There is a tender medial joint and pain with McMurray's testing. The claimant failed conservative treatment including medications and a home exercise program. As noted by the ACOEM Guidelines, the claimant has failed to respond to conservative treatment and remains symptomatic; therefore, the left knee arthroscopy is recommended as medically necessary. Based upon the ACOEM Guidelines, the Reviewer recommends overturning the previous denial for left knee arthroscopy and deems it medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Knee, Diagnostic Arthroscopy

ODG Indications for Surgery<sup>TM</sup> -- Diagnostic arthroscopy:

Criteria for diagnostic arthroscopy:

1. Conservative Care: Medications. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS
3. Imaging Clinical Findings: Imaging is inconclusive.

**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)