



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 05/16/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left knee arthroscopy

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

Board Certified in Orthopedic 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations at Clinic with, M.D. dated xx/xx/xx and 01/30/07
A receipt from the pharmacy for Prevacid/Napra-Pak dated 02/03/07

An MRI of the left knee interpreted by, M.D. dated 02/06/07
Evaluations with, M.D. dated 02/22/07, 03/29/07, and 04/19/07
A precertification form from an unknown provider (no name or signature was available) dated 03/16/07
A precertification form from Dr. dated 03/21/07
A peer review from dated 03/27/07
Letters of non-authorization dated 03/27/07 and 04/05/07
A History and Physical Examination at Center with Dr. dated 04/04/07
An undated timeline of the injury from the claimant along with medical records

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, Dr. placed the claimant on restricted work duties and prescribed Prevacid/Napra-Pak. It was felt she might have a possible meniscal injury. An MRI of the left knee interpreted by Dr. dated 02/06/07 revealed a medial meniscal tear and degenerative changes in the knee. On 02/22/07, Dr. recommended steroid injections of the knee. He noted it was more likely that the symptoms were from the torn meniscus than from the degenerative changes with arthritis, which would be more chronic in nature. He noted if the claimant responded favorably and things settled down, then most of her pain was arthritic in nature. On 03/21/07, Dr. requested left knee surgery. On 03/27/07 and 04/05/07, wrote letters of non-authorization for left knee surgery. On 03/29/07, Dr. stated the claimant was given an intrarticular injection of corticosteroids that did not result in significant resolution of symptoms. Therefore, he felt there was a high likelihood that her mechanical symptomology was referable to the torn meniscus. He felt the appropriate action was arthroscopic medial menisectomy. On 04/19/07, Dr. noted the claimant was requesting a utilization review for the arthroscopy.

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

The patient has very significant chondromalacia and degenerative changes, along with horizontal tear of the posterior horn of the medial meniscus. There are moderate to severe degenerative changes in the medial and patellofemoral compartment of the left knee. The medical records do not demonstrate any progressive non-surgical treatment. Essentially, the patient was recommended to have surgery almost at the onset of treatment by the surgeon. She has not been treated with anti-inflammatory medication, physical therapy, or injections of Synvisc or identical molecules. It is well known that arthroscopy for a degenerative condition does not lead to permanent changes. The degenerative changes within the knee are not related to the occupational injury. In my opinion as a board certified orthopedic surgeon, the requested outpatient left knee arthroscopy is neither reasonable nor necessary as related to the original injury, but would be treating the underlying degenerative disease.

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 AND KNOWLEDGE BASE**
- 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)**