

**Parker Healthcare Management Organization,
Inc.**

4030 N. Beltline Rd Irving, TX
75038
972.906.0603 972.255.9712
(fax)

Notice of Independent Review Decision

DATE OF REVIEW: APRIL 7, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed left knee arthroscopy/EUA/excision torn meniscus (29881)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
ee)
- XX Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
719.46	29881		Prosp	1					Overturn

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained a work related on the job injury on xx/xx/xx.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The medical necessity for repeat surgery is based on clinical judgment. While it is indeed possible that the MRI changes are postoperative vs. further tearing, given the discrepancy and inability to be more accurate (with the possible exception of an MR/arthrogram) the decision tilts toward the treating surgeon. There is no peer-reviewed, double blind, prospective, level I or level II literature which answers this question. ODG guidelines were reviewed but ODG guidelines are simply that – guidelines, and cannot be expected to answer each and every issue arising in he practice of medicine. The patient has had adequate non-operative care and has failed to improve. Therefore, the procedure requested is deemed medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX 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)