

Notice of Independent Review Decision
Report dated incorrectly

DATE OF REVIEW: 08/09/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left knee arthroscopy and with meniscectomy (medial and lateral) including shaving and chondroplasty.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., Board Certification: American Board of Orthopedic Surgery, with extensive experience in the evaluation and treatment of patients suffering multiple injuries as a result of falls

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

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

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
717.7	29881	NA	Prosp						Upheld
717.7	29877	NA	Prosp						Upheld

INFORMATION PROVIDED FOR REVIEW:

- TDI case assignment
- URA correspondence 07/28/08, letters of denial 06/26 & 07/03/08, including criteria used in the denial (ODG)
- Orthopedic evaluations and progress notes 01/18/08 – 07/09/08
- Radiology reports 03/28/08 and 06/11/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This xx-year-old female fell on xx/xx/xx, suffering a fracture of the proximal humerus. Approximately six weeks after injury, she began complaining of left knee discomfort. Evaluation of her left knee revealed periodic minimal effusions. An MRI scan revealed a chondral defect in the patella and a subchondral cyst. There was no defined meniscal tearing demonstrated. Medial collateral ligament sprain was suggested.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

It does not appear that this patient meets the ODG criteria for the performance of diagnostic arthroscopy. The lesions defined on the MRI scan are not likely to be significantly benefited by arthroscopic surgery. Meniscal tearing has not been defined.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 national accepted medical literature (provide a description).
 - Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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