

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 05/31/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee EUA, arthroscopy, excision torn portions medial and lateral meniscus

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

M.D., 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)

Upon independent review the reviewer finds that the requested left knee EUA, arthroscopy and excision of torn portions medial and lateral meniscus is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 3/26/08, 3/7/08

ODG Guidelines and Treatment Guidelines

Operative Reports 4/10/07, 2/13/07

Surgery Report, MD 3/13/08, 3/6/08, 2/21/08

, MD 3/19/08, 3/3/08, 4/25/07, 2/28/07, 2/14/07, 1/31/07, 3/16/07, 2/21/07, 7/2/07, 5/23/07, 5/9/07, 4/11/07, 8/1/07, 7/13/07, 4/9/07

, MD 3/8/07, 4/5/07, 8/28/07, 7/3/07, 10/9/07, 10/2/07, 10/15/07

, MD NCS?EMG 6/13/07

MRI Left Knee 3/9/07, 10/4/05, 1/23/07, 5/22/07
, MD 4/3/06, 5/18/06
Radiology Report 4/3/06
FCE 9/18/07
Approvals for Work hardening, Individual Psychotherapy, Active Therapy, Repeat MRI
Medical Evaluation, MD 3/19/08
, MD 9/12/07, 5/13/08
8/29/07
Daily Notes, PT Notes and Progress Notes from October 2006 to November 2007
Biofreeze Prescriptions 10/5/07, 8/28/07
Assessment 4/23/08
, MD 10/23
, MD 7/18/07
, MD 7/2/07, 12/4/07, 12/14/07, 1/30/08, 3/17/08
Peer Review 3/26/07, 4/20/07
, DC 3/25/08, 3/26/08
Impairment Evaluation 11/12/07
FCE 12/4/07
Physical Performance Evaluation 10/2/06
, DO Peer Review 12/27/07
Approval, Outpatient EUA 3/7/08
Approval, Sympathetic Block Series 2/29/08
Denial Letters and Notes 3/5/08, 3/7/08, 3/24/08, 3/26/08, 3/28/08
Notice of Disputed Issues 5/7/08
Head CT, Chest PA and Lateral 6/1/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old male injured worker whose injury dates back some years to xx/xx/xx when he reportedly injured his knee. His original MRI revealed a discoid meniscus on the lateral side but no tears. He subsequently has undergone three arthroscopic surgeries. He has a current diagnosis of chronic regional pain syndrome type I and he has a current MRI without gadolinium intra-articularly which reveals some post-surgical changes in the posterior horn of the lateral meniscus as well as the anterior horn of the meniscus. There is no clear-cut evidence of a grade III meniscal lesion on this current image. There is, however, significant chondromalacia noted. He has had semi-invasive pain management, to which he appears to have responded at least initially. Current request is for further arthroscopic surgery.

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

Upon independent review of the provided medical records and ODG Guidelines, the reviewer finds that the requested left knee EUA, arthroscopy and excision of torn portions medial and lateral meniscus is not medically necessary. The previous adverse determination is upheld due to the fact this patient has had three unsuccessful surgeries coupled with the fact that there is little indication on the current MRI that there is a surgical lesion. He certainly has significant chondromalacia as has been documented. The chronic regional pain syndrome type I is at the very least a relative contraindication for further surgical intervention, and for this type of repeat imaging, intra-articular gadolinium would have been appropriate. It is for these reasons that it is not possible to overturn the previous adverse determination.

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)