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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/03/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy, Knee, Diagnostic, without or without synovial biopsy (separate procedure)

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 2/12/09, 3/3/09
Peer Reviews, 2/11/09, 2/27/09
MD, 2/2/09, 1/19/09, 3/23/09
MRI of the Knee, 2/2/09, 9/11/07
MD, 1/5/08
Operative Report, 2/11/08
Operative Report, 5/31/07
Discharge Summary, 6/4/07
DDE, 5/20/08
FCE, 5/27/08

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who apparently sustained an open fibular fracture and underwent open debridement. He had a previous arthroscopy where the internal structures of the knee were apparently found to be benign in terms of the lateral compartment in particular. The medial gutter was found to be benign. The suprapatellar pouch revealed a plica. The patella and trochlear areas were normal. The intercondylar notch was benign, and the anterior

cruciate ligament was found to be intact. The lateral compartment was benign, and the lateral gutter was benign. The medical records showed some laxity of the lateral side of the knee, but this has not been documented as to what grade it may or may not be, and there is said to be by the treating physician possibly a subtle posterolateral corner laxity. Current request based on the records provided to this reviewer is for a knee arthroscopy, diagnostic, with or without a synovial biopsy. The reviewer records and the medical records seem to indicate the surgeon in fact wants to perform either lateral collateral ligament advancement or posterior lateral corner repair.

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

Based upon the medical records and the previous arthroscopy and the MRI scan findings, there is no evidence of internal problems within the knee that would require arthroscopic evaluation as per the ODG. The guidelines for synovial biopsy are not met. The indications for a lateral reconstruction whether of the collateral ligament or the posterolateral corner have not been met as the medical records do not address this specifically as is required. The previous reviewer has noted that grade 1 or 2 lesions typically respond well to conservative care, and the reviewer cannot determine from the records provided for this review whether this is a grade 3 lesion or not. Furthermore, the MRI scan does not indicate that there is any disruption of the posterolateral corner or the lateral collateral ligament. The medical provider does not indicate the reasons why the ODG Treatment Guidelines should be overturned in this patient's case. It is for these reasons that this provider is not in the position to overturn the previous adverse determination. The reviewer finds that medical necessity does not exist for Arthroscopy, Knee, Diagnostic, without or without synovial biopsy (separate procedure).

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

ACOEM-AMERICA 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)