

I-Resolutions Inc.

An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscope Left Knee: ACL Repair; Arthroscope Left Knee: Medial Adhesion; Arthroscope Left Knee: Lateral Adhesion (29888, 29880, 29876)

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, 7/2/09, 7/23/09
IRO Summary from Carrier, 8/7/09
PT visits x 10, 10/6/08-12/3/08
MRI Lumbar, 2/10/09
MRI knee, 2/10/09
Exam Hand, 9/19/08
Exam Knee, 9/19/08
DO, 9/19/08
MD, 9/24/08
Dr. 10/10/08
MD, 10/20/08
12/3/08
MD, 12/3/08
Dr. 2/10/09
Dr. 2/23/09, 5/11/09
Dr. 3/3/08
Dr. 6/29/09
Dr. 3/26/09
MD, 3/15/09

Employers First Report of Injury, xx/xx/xx
Back Institute, 2/17/09, 5/11/09

PATIENT CLINICAL HISTORY SUMMARY

This is a patient who sustained an injury resulting in complaints of back and knee pain on xx/xx/xx. She is stated to have a body mass index of 42.9. Physical examination revealed a 2+ anterior drawer with positive pivot shift test. The MRI scan revealed some increased signal but intact anterior cruciate ligament fibers. The menisci were normal with only meniscal signal change and no tear. Current request is for anterior cruciate ligament reconstruction.

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

Based upon the patient's MRI scan results, there is no surgical indication in this individual. The clinical examination is at great variance with the objective MRI scan results. It is for this reason that this patient does not satisfy ODG Guidelines. It is for this reason the previous adverse determination is upheld. The reviewer finds that medical necessity does not exist for Arthroscopy Left Knee: ACL Repair; Arthroscopy Left Knee: Medial Adhesion; Arthroscopy Left Knee: Lateral Adhesion (29888, 29880, 29876).

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)