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Notice of Independent Review Decision

DATE OF REVIEW: 11/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of outpatient right knee arthroscopy, post-op knee brace, and cryotherapy unit rental for 7 days.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 15 years and performs this type of service in daily practice.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of outpatient right knee arthroscopy, post-op knee brace, and cryotherapy unit rental for 7 days.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr. and xxxx

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr. : Office Notes – 8/10/09-8/20/09.

Records reviewed from xxxxx: , MD letter – 11/16/09, Denial Letters & Rationale– 8/25/09 & 9/29/09, Notes – 7/23/09-9/21/09; xxxxx

Pre-authorization request – 8/20/09, Appeal – 9/21/09, DME Prescription Form – 8/20/09; L Farolan, MD MRI report – 7/23/09; xxxx xxxx WC Notes – 4/29/09-7/16/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee fell onto his right knee on xx/xx/xx. xxxx xxxx WC records reflected no initial knee swelling and a diagnosis of knee abrasion and sprain. Records from Dr. revealed persistent intermittent knee pain and joint line tenderness in a xxxx inches tall, xxxxx lb., diabetic and hypertensive individual. An MRI of the knee on xxxxx documented medial meniscal degeneration and DJD.

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

The medical necessity of the procedure (and associated post-op DME) has not been reasonably established as medically necessary at this time. The rationale for this opinion is the records do not reflect consistent findings compatible with a torn meniscus or other form of internal derangement diagnosis, as per (ODG) Guidelines. The injury mechanism (a direct contusion due to fall) was atypical for a loading-twisting injury more associated with meniscal tear. The lack of early and/or ongoing significant joint effusion also points away from internal cartilage injury. The ODG supports the presence of two symptoms and two exam findings (overall not present consistently within the record) as being requisite to decrease the probability of 'low return' arthroscopic evaluation-surgery. The MRI imaging study is not consistent with an established meniscal tear which is another requisite of the ODG Guidelines. However, the most salient feature of the record is the lack of evidence of attempted/failed non-operative treatment such as physical therapy, restricted activities, bracing aspiration and/or injections (such as viscosupplementation, repeat cortisone). Therefore, intermittent complaints and some joint line tenderness (which could be associated with chronic osteoarthritis in this large body habitus individual), the lack of + criteria for establishment of a diagnosis of persistent internal injury and especially the lack of documented failure of reasonable conservative treatment do not currently support medical necessity for the proposed procedure and post-op DME.

This reviewer's opinions have been based on clinical experience and both the *Official Disability Guidelines* web-based guidelines and *The American College of Occupational and Environmental Medicine*, Second Edition, practice guidelines, from the chapters related to the Knee, including the section on Special Studies, Diagnostics, and Treatment.

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)