

SENT VIA EMAIL OR FAX ON
Jan/05/2009

True Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/05/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lt knee scope / menisc /ACL ronc. / patella shaving

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

OD Guidelines

Denial letters, 11/10/08 and 12/05/08

Records from , 10/07/08 through 11/05/08

MRI scan, 10/01/08

Records from , 10/06/08

PATIENT CLINICAL HISTORY SUMMARY

This is a xx-year-old female who was injured at work. She relates she is a and slipped and fell on her left knee while delivering lunch to a classroom on xx/xx/xx. A left knee MRI scan on 10/01/08 revealed a chronic complete anterior cruciate ligament tear, a tiny flap of the posterior horn of the medial meniscus, and chronic lateral collateral ligament tear and tendinopathy of the popliteal ligaments. She was found on examination to have pain on the lateral and medial aspects of the knee associated with locking and giving way, an antalgic gait, decreased flexion, and laxity with Lachman's test. She was subsequently seen by Dr. on 11/04/08 with continued symptoms. His examination revealed restriction in flexion and extension and obvious laxity of the ACL with soft endpoint. An MRI scan revealed, as mentioned above, what was a complete tear of the ACL reported as "chronic" as well as a flap tear of the medial meniscus. Current request is for ACL reconstruction as well as meniscectomy and probable patellofemoral debridement.

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

Based on the ODG Guidelines, of importance is that this lady is, in fact, less than xx years old. She does have the clinical symptomatology necessary, based on the history and physical examination and ODG Guidelines, to undergo this procedure. She has a sufficient number of criteria required under the ODG Guidelines as the Reviewer interprets from the medical records, and the Reviewer's medical assessment is that, given her young age, the MRI scan findings, physical examination showing both the pivot shift and greater than 5 mm laxity, that she does, indeed, meet the ODG criteria for the ACL reconstruction. She has ongoing subjective complaints of joint pain and swelling as well as limited range of motion, etc., and she appears to fill the criteria not only for the ACL reconstruction but also for the chondroplasty that is proposed in the medical records. It is for this reason that overall this reviewer feels that the ODG criteria have been, at least in spirit, fulfilled, and certainly the MRI scan is unequivocal as well as the physical examination. Hence, this reviewer finds the medical necessity of this procedure per the ODG Guidelines to be present.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)