



Southwestern Forensic  
Associates, Inc.

Amended July 31, 2009

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 07/24/09

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Arthroscopy with medial and lateral meniscectomy, left microfracture picture technique, and cold therapy unit with pad.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering knee injury

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. SWF forms
2. TDI referral
3. Denial letters, 01/28/09 and 02/10/09
4. Carrier records
5. Letters from law firm dated 07/09/09 and 08/06/09
6. TWCC-73 forms, ten entries between 10/01/07 and 06/30/09
7. Clinical notes, D.O., eight entries between 08/27/08 and 05/04/09
8. Rehabilitation Evaluation, 08/28/08
9. PT knee evaluation, 09/11/08
10. Shoulder evaluation, 09/11/08 and re-evaluation 10/09/08
11. Progress note, 09/15/08
12. MRI scan of left shoulder, 08/11/08
13. MRI scan of left knee, 08/01/08

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14. Notice of Adverse Determination, 08/20/08
15. Utilization Review records, 10/23/07, 01/28/09, 02/10/09, and 03/17/09
16. Medical Center records, 10/01/07, 10/03/07, and 10/09/07
17. TWCC-69, 12/02/08
18. Evaluation Center evaluation 12/02/08
19. Authorization for physical therapy, 03/16/09
20. URA records
21. Various fax cover sheets
22. Request for precertification department

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient is a xx-year-old female who suffered an injury to her left shoulder and her left knee in a fall at work on xx/xx/xx . She has undergone extensive treatment with physical therapy, medications, and local injections. She has persistent left knee symptoms and some suggestion of internal derangement of the knee. The exact nature of the internal derangement is not clear, and the confounding issue remains a negative MRI scan dated 08/01/08. The MRI scan did not demonstrate a medial meniscus tear, and the request for surgical preauthorization is specifically for arthroscopic lateral and medial meniscectomy. The patient has physical findings which suggest internal derangement.

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

The patient has a history of mechanism of injury suggestive of contusion of the knee, and she was for a while treated with that diagnosis. An MRI scan that was obtained on 08/01/08 did not demonstrate tearing of the menisci. She has had persistent symptoms in spite of physical therapy, medications, and activity modifications. She has some physical findings which might suggest internal derangement of the knee; however, the exact nature of that internal derangement is not clear. Until such time as a more current MRI scan is obtained, the medical necessity for arthroscopic meniscectomy cannot be justified. The medical necessity for such has not been established.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.

- ODG-Official Disability Guidelines & Treatment Guidelines, 2008, Cervical Spine Chapter, Discography passage.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)