

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Knee examination under anesthesia, arthroscopy, arthroscopic surgery and possible arthrotomy with saphenous nerve block and macraine block

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

M.D., Board Certified Orthopedic Surgeon

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, 5/22/09, 6/4/09

Office notes, Dr. 04/07/09, 04/20/09

CT scan, 04/10/09

X-ray left lateral and sunrise views, 04/27/09

Texas Workers' Compensation Work Status Report, Dr. 04/27/09

Office notes, Dr. 04/27/09, 05/05/09, 05/19/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who suffered a work related injury on xx/xx/xx when he lost balance, fell forward and impacted his left knee. Since that time the claimant has had constant knee pain and swelling. He had a CT scan of his knee done on 04/10/09 that revealed no evidence of a fracture, a joint effusion and degenerative changes to the patellofemoral joint. He originally treated with Dr. and had left knee X-rays done on 04/27/09. Left lateral and sunrise views revealed that the bony density was good, the patella was centralized with mild degenerative changes that included the patellofemoral joint. Standing AP views revealed that the joint spaces were well maintained, alignment was good, the bony density was adequate, the patella was centralized and there were mild degenerative changes. Dr. referred the

claimant to Dr. for treatment. Dr. diagnosed the claimant with internal derangement of the left knee and ordered physical therapy. When the claimant last saw Dr. on 05/18/09, his knee swelling had increased, his range of motion was 10 degrees to 110 degrees and his McMurray's sign was equivocal to positive. Dr. noted that the claimant's left knee had not improved with physical therapy and the swelling had increased. Because the claimant could not have an MRI due to his pacemaker, Dr. recommended an arthroscopy exam.

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

Based on review of the medical record provided, evidence based medicine, and ODG, the reviewer would recommend as medically necessary this arthroscopic exam under anesthesia, arthroscopy with arthroscopic surgery and arthrotomy. The claimant has exhausted conservative care after now greater than three months of treatment. Objective physical examination findings included bruising, effusion, decreased range of motion, and pain medially. The claimant has been treated appropriately with physical therapy, anti-inflammatory agents, and restrictions. Based on failure to respond to conservative care of over greater than three months, the reviewer finds that medical necessity exists for Knee examination under anesthesia, arthroscopy, arthroscopic surgery and possible arthrotomy with saphenous nerve block and macraïne block.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates. Knee & Leg

Diagnostic arthroscopy

Criteria for diagnostic arthroscopy

1. Conservative Care: Medications. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS
3. Imaging Clinical Findings: Imaging is inconclusive.

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)