



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 05/31/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopic medial and lateral meniscal debridement, chondroplasty, and lateral retinacular release, left knee

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

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

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. Forensic Associates forms
2. TDI referral forms
3. Denial letters, 04/17/09, 04/30/09
4. URA records
5. Evaluations, M.D., 02/12/09 and 03/19/09
6. Demographics and referral, Orthopedic Group surgical request, 04/13/09 and 04/24/09
7. Clinical notes, M.D., 03/26/09, 04/23/09, 03/19/09, and 03/25/09
8. MRI scan of left knee, 02/23/09
9. Requestor records

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This unfortunate male suffered a fall at work with an injury to his left knee. He has had evaluations including joint line tenderness. His symptoms appear to be anteriorly

located. He has reported positive McMurray's sign. The MRI scan essentially reveals tears of both the medial and lateral menisci. There are no significant cartilaginous defects and no subluxation of the patella documented.

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

The request for surgical preauthorization includes multiple procedures including arthroscopic medial and lateral meniscal debridement, chondroplasty, synovectomy, and lateral retinacular release. There are requests for preauthorization for which clinical documentation is insufficient to justify approval. The prior denial of this multiple procedure surgical request was appropriate and should be upheld. The medical necessity for each of the requested procedures 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.)