

Core 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-8368
Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left knee scope 73721

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

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 3/30/09, 4/16/09

Progress Notes, 3/16/09, 4/20/09, 4/13/09, 3/30/09, 3/23/09

MRI of the left knee w/o contrast, 3/20/09

PATIENT CLINICAL HISTORY SUMMARY

This injured worker twisted his knee on xx/xx/xx in deep seed. He was denied the requested procedure previously due to lack of physical therapy. According to the records provided for this review, the patient had a home exercise program. He was also sent for physical therapy. He has taken nonsteroidal anti-inflammatories after the fact. He continues to be symptomatic with pain and swelling and giving way. The current request is for Left knee scope 73721.

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

As of the writing of this review, this patient has satisfied the ODG criteria for the requested procedure, i.e., pain, medial joint line tenderness, effusions. He has had medications, physical therapy, and home exercises. He has a positive MRI. He has ongoing swelling, crepitus and popping. He has failed conservative care. The records show he has a complex tear of the medial meniscus that is large and has not been amenable to conservative

treatment. The patient has satisfied the ODG Official Disability and Treatment Guidelines for this procedure as well as clinical judgment and general medical experience. It is for this reason that the previous adverse determination was overturned. As of this time, this patient satisfies the statutorily mandated Guidelines. The reviewer finds that medical necessity exists for Left knee scope 73721.

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)