

SENT VIA EMAIL OR FAX ON
Sep/24/2009

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Knee Arthroscopy, Meniscectomy, Synovectomy and Lateral Release

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

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

OD Guidelines

MRI right knee, 6/8/09

Office note, Dr. 7/17/09

Re-evaluation of MRI, 7/24/09

Peer review, 8/3/09, 08/26/09

Office note, 8/14/09

Office note, Dr. 8/31/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who apparently sustained a right knee injury in a fall on xx/xx/xx. The records indicated treatment consisted of medications, therapy, and injections. MRI on 06/08/09 revealed a complex tear involving the posterior horn and body of the medial meniscus with truncation of the mid body and small meniscal fragment in between the medial collateral ligament and the medial femoral condyle. There was an associated grade 1 to 2 sprain of the medial collateral ligament and chondral erosion within the weight-bearing surface of the medial femoral condyle. Right knee arthroscopy with meniscectomy, synovectomy, and lateral release was requested.

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

Given the documentation of considerable conservative care in this case including medications, therapy, and injections, arthroscopic treatment is in all likelihood indicated at this time. However, arthroscopic treatment would be directed at meniscal pathology and at medial compartment degeneration. The records provided do not include any clear indication for lateral retinacular release. As such, the Reviewer would not be able to recommend as medically necessary the procedure in total.

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)