

SENT VIA EMAIL OR FAX ON
Nov/02/2009

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/02/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Knee Menisectomy, Debridement, Synovectomy

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

Office note, Dr. 7/28/09, 08/10/09

MRI left knee, 8/3/09

Peer review, 9/10/09, 09/14/09

Claimant letter, 10/5/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who injured his left knee on xx/xx/xx while lifting a water heater into a dumpster. He subsequently underwent left knee arthroscopy on 04/26/06. The indication for surgery and the surgical findings were not provided for review. Left knee pain persisted. MRI on 08/03/09 noted a complex oblique horizontal tear involving the posterior horn of the medial meniscus reaching the inferior articulating surface and extending into the body of the medial meniscus. There was grade II –III mild and patchy grade III chondromalacia noted along the medial femoral compartment as well as a small joint effusion. A brief office visit on 08/10/09 noted symptoms mostly related to the lateral aspect of the distal thigh. Left knee arthroscopy was recommended and the claimant requested a second opinion, the report of which was not

available for review.

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

The requested repeat left knee arthroscopic surgery cannot be justified based on the information reviewed.

Though the claimant's letter of 10/05/09 indicates a history of remote therapy and corticosteroid injections, it is not clear if the claimant has received any recent conservative care. It is also unclear if the claimant has mechanical symptoms in the knee joint.

ODG guidelines require conservative care before pursuing meniscal surgery in the absence of a locked or a blocked knee.

For these reasons, the requested surgery cannot be justified based on the information provided for review.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates, Knee and Leg

Indications for SurgeryTM -- Meniscectomy:

Criteria for meniscectomy or meniscus repair (Suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positive):

1. Conservative Care: (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. PLUS

2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS

3. Objective Clinical Findings (at least two): Positive McMurray's sign. OR Joint line tenderness. OR Effusion. OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS

4. Imaging Clinical Findings: (Not required for locked/blocked knee.) Meniscal tear on MRI. (Washington, 2003)

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 KNOWLEDGBASE

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)