



Notice of Independent Review Decision

DATE OF REVIEW: 1/5/10

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for right knee scope and lateral meniscectomy.

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

Texas licensed 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for right knee scope and lateral meniscectomy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Utilization Review Findings dated 12/17/09.
- Designated Doctor Examination Report/letter dated 11/23/09.
- Medical Determination Letter dated 11/5/09, 9/29/09.
- Peer Review dated 11/5/09, 9/29/09.

- Examination Notes dated 9/24/09.
- Right Knee MRI Results dated 9/17/09.
- Request for Treatment Authorization Form (unspecified date).

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Slipped and fell.

Diagnosis: Left knee lateral meniscus tear with degenerative changes.

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

This male sustained a right knee injury on xx/xx/xx. Per Dr. note, the claimant was a xxx and injured his knee when he slipped on the second step and fell onto his knees. Per Dr. description, the claimant fell, landing on his right knee while attempting to adjust a mirror on a municipal bus. The initial diagnosis was left knee lateral meniscus tear with degenerative changes. The MRI of the right knee was done on 09/17/09 and showed a complex tear involving the entire lateral meniscus. There was some loss of meniscal substance along the posterior horn and body, some of which might be partially flipped anteriorly and there was a cleavage tear throughout the entire length of the meniscus. There was intra meniscal mucoid degeneration of the posterior horn and body of the medial meniscus. There was also degenerative subchondral cyst formation measuring about 16 x 8 mm along the posterior medial margin of the tibia related to full thickness overlying articular cartilage degeneration. On 09/24/09, Dr. evaluated the claimant. On exam, the claimant had a slight antalgic gait, slight effusion, tenderness of the lateral joint line and a positive McMurray. The physician recommended surgery. Authorization was requested for a right knee scope and lateral meniscectomy. The surgery was denied on a previous peer review. On 11/23/09, Dr. performed a designated doctor evaluation. He indicated that the claimant had not reached maximum medical improvement (MMI) and needed right knee surgery. The evidence based ODG recommend meniscal surgery for individuals who have failed conservative care, have subjective complaints of pain consistent with the findings on exam and have supportive imaging studies. An MRI scan report documented a complex tear of the lateral meniscus. Reportedly, the claimant continued to complain of pain over the lateral aspect of his knee. This was documented on multiple examinations, including in a more recent examination in November. With the assumption that this claimant was several months from his date of injury and had clinical complaints consistent with imaging study findings, one would recommend the surgery as being reasonable and medically necessary, at this point. The above statement is made assuming that conservative care had been addressed, at the very least, in terms of activity modification over several months and that it

was unlikely, based on the joint line complaints that were consistent with imaging study findings, that further conservative care is going to offer meaningful improvement in this claimant's symptoms. Of note, although this claimant's age is such that one may be concerned about underlying degenerative changes, the records described relatively slight degenerative changes; as such options such as diagnostics and therapeutic cortisone steroid injections would not necessarily be indicated before proceeding with surgical intervention. The request for surgical arthroscopy is considered reasonable and medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web), 2009, Knee – Meniscectomy.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).