

Notice of Independent Review Decision

**DATE OF REVIEW: 03/09/2010**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Left knee arthroscopy loose body removal

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment

**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.

It is determined that the left knee arthroscopy loose body removal is not medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 02/26/10
- Letter of determination– 01/20/10, 02/10/10, 02/12/10
- Preauthorization request by Dr.– 02/02/10
- Report of MRI of the left knee – 04/18/08
- Progress notes by Dr.– 01/11/10
- Follow-up consultation by Dr.– 09/10/09, 10/22/09
- Weekly therapy summary by Dr.– 09/21/09 to 11/06/09
- Post operative PPE by Dr.– 10/04/09
- Prescription for Vicoden – 01/13/10
- Pre-authorization Request by Dr.– 01/14/10
- Reconsideration for MRI by Dr.– 01/11/10
- Report of x-ray of the right ankle – 05/08/08
- Report of MRI of the right knee – 04/15/08
- Request for MRI left knee and arthrography right knee – 12/23/09
- Pre-authorization for PT by Dr.– 10/19/09

- Pre-authorization for injections by Dr.– 10/15/09
- Office visit notes by Dr.– 10/04/09 to 10/06/09
- Letter from Dr.– 07/14/09

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when she stepped from her truck that had been lifted by a wrecker and fell. She sustained multiple injuries to her lower extremities including fractured lateral malleolus right, sprain right knee, rule out meniscus tear right knee, internal derangement of the left knee and chondromalacia patella, left knee. The patient has been treated with physical therapy as well as surgical intervention. An MRI of the left knee has revealed a loose body in the intracondylar notch anterior to the ACL. There is a request for left knee arthroscopy loose body removal.

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

This patient was injured in xx/xxxx. She had a fractured fibula on the right and right and left knee injury. She had an arthroscopy of the right knee a year later with mixed results. The patient has more pain in the right than the left knee and the left knee has had full range of motion of the knee based on the physical therapy follow up notes. There is no instability, no history of locking of the left knee and no swelling. An MRI of the left knee indicates no ligamentous tear, no meniscal tear and a questionable loose body. There is no evidence of locking, swelling or instability. This patient does not meet the ODG guidelines for arthroscopy of the knee.

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

- 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 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)