

SENT VIA EMAIL OR FAX ON
Nov/22/2010

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Purchase of Cryotherapy Unit and Cuff; 1 Left Knee Medial Meniscectomy with Hardware Removal

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 left knee: 10/13/08

Dr. OV: 07/13/09, 08/24/09, 10/01/09, 11/18/09, 03/31/10, 07/07/10, 08/16/10
clinic: 01/22/10

Chronic pain management program: 02/01/10-02/05/10

Dr. Medical Evaluation: 06/01/10

Peer Review: 07/29/10, 09/02/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a work related injury to his left patella on xx/xx/xx when he fell on steel steps and landed on his left knee. An MRI of the left knee on 10/13/08 demonstrated a comminuted interarticular fracture of the patella, moderate sized knee joint effusion and severe diffuse subcutaneous hemorrhage and edema. The claimant underwent an open reduction and internal fixation of his left patella on 10/23/08 and a manipulation

under anesthesia of his left knee on 01/02/09. When the claimant saw Dr. on 11/18/09 he had had a steroid injection that gave him temporary relief. On examination his left quadriceps was noted to be weak and he had palpable hardware. Dr. recommended hardware removal, but the claimant did not want to proceed so Dr. referred the claimant back to pain management. The claimant's complaints had not changed when he saw Dr. on 03/31/10. On examination the claimant lacked 3-5 degrees of full extension. He still had weakness and quadriceps atrophy with medial joint line tenderness and a positive McMurray test. X-rays of his left knee revealed a well-healed fracture. Dr. recommended removal of the symptomatic hardware and a meniscectomy followed by rehabilitation protocol/work conditioning program. A medical evaluation by Dr. on 06/01/10 reported that the claimant had reached maximal improvement on 06/01/10 and was given a whole person impairment rating of 3 percent. When the claimant saw Dr. on 07/07/10, he decided to have his hardware removed. This was non-certified in a peer review on 07/29/10 as there was minimal objective documentation of the claimant's failure to respond to conservative treatment. In his office note of 08/16/10, Dr., stated that the claimant had had physical therapy, manipulation and a steroid injection, none of which alleviated his symptoms. A peer review on 09/02/10 non-certified the surgery because there was no documentation in the MRI of a meniscal tear.

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

Meniscectomy is not medically indicated and appropriate in this male who had undergone open reduction internal fixation of the patella on 10/23/08 and manipulation under anesthesia on 01/02/09. There is only one MRI available for review on 10/13/08, which did not demonstrate any meniscus pathology. Thus, based on these objective findings, the rationale for the requested meniscectomy is unclear. There is documentation in the medical records that the hardware is symptomatic, but it is unclear whether a hardware block has been performed to isolate this as the source of symptomatology. Therefore, the surgery as requested is not indicated and appropriate.

A purchase of a cryotherapy unit and cuff are not medically indicated and appropriate as these are typically used as postoperative treatments and the surgery is not indicated and appropriate and this is consistent with the guidelines.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Updates. Knee and Leg

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)