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Notice of Independent Review Decision

DATE OF REVIEW: 08/08/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left knee arthroscopy, debridement, and lateral and medial meniscectomy

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

Board Certified in Orthopedic Surgery

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.

Outpatient left knee arthroscopy, debridement, and lateral and medial meniscectomy - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 06/03/11 and 06/09/11
A request for laboratory studies dated 06/03/11 from M.D.
Laboratory studies from Hospital collected on 06/03/11
A preauthorization request for a left knee MRI from Dr. dated 06/03/11
A request for an MRI from Dr. dated 06/06/11
A verbal notification from for a left knee MRI dated 06/06/11
An MRI of the lower extremity dated 06/07/11 and interpreted by, M.D.
A DWC-73 form signed by Dr. on 06/09/11
Preauthorization requests from Dr. dated 06/09/11 and 06/22/11 for a left knee arthroscopy with debridement and lateral and medial meniscectomies
Notifications of adverse determinations from dated 06/14/11 from M.D. and dated 07/14/11 from M.D.
A letter addressed to Insurance Company from Dr. dated 06/15/11
An acknowledgement of reconsideration request from dated 07/01/11
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

Dr. evaluated the patient on 06/03/11 for a left knee injury occurring on xx/xx/xx. He had knelt down to cut a board and felt pain and a pop in the left knee with instant pain and swelling. The patient's past medical history was significant for a left knee arthroscopic debridement, chondroplasty, and meniscectomy. The patient was given crutches Lortab and referred for an MRI of the left knee. An MRI of the left knee dated 6/07/11 revealed an ACL tear, meniscal tears involving the medial and lateral menisci, degenerative changes, large amount of joint fluid, and soft tissue edematous changes. On 06/09/11, Dr. reviewed the MRI. The impressions were effusion of the joint, knee pain, possible torn meniscus, and possible ACL sprain/injury. Dr. recommended arthroscopic debridement and lateral and medial meniscectomies. On 06/14/11, Dr. provided a notification of adverse determination for the left knee arthroscopy, debridement, and lateral and medial meniscectomies. Dr. also provided a notification of adverse determination dated 07/14/11 for the left knee arthroscopy, debridement, and lateral and medial meniscectomies.

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

The ODG criteria for diagnostic arthroscopy are: 1) conservative care, medications or physical therapy; 2) subjective clinical findings to include pain and functional limitations despite conservative care; and 3) imaging is inconclusive. The ODG criteria for meniscectomy note that it is recommended for symptomatic meniscal tears, but is not reasonable for osteoarthritis in the absence of meniscal findings. Asymptomatic surgery for knee osteoarthritis offers no added benefit to optimize physical and medical therapy. The ODG criteria for meniscectomy are: 1) conservative care, physical examination, and medications or active modifications; 2) subjective clinical findings (at least two to include joint pain or swelling or feeling of giving way, or locking, clicking, and/or popping; 3) positive McMurray's or joint line tenderness or effusion or loss of range of motion or loss of clicking, popping, or crepitus; and 4) meniscal tear on MRI scan.

The patient's diagnosis appears unclear at this point. The positive crystals noted in the aspiration have not been addressed and it has not been addressed whether the patient may have gout or pseudogout. There has not been an adequate trial of conservative treatment with objective documentation of the patient's clinical response. The requested procedure does not meet the evidence based ODG criteria as outlined above. Therefore, the requested outpatient left knee arthroscopy, debridement, and lateral and medial meniscectomy are not appropriate and the previous adverse determinations should be upheld.

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

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- 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)

Medical Disability Adviser