



MedHealth Review, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: 2/24/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a left knee scope and assistant.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a left knee scope and assistant.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PATIENT CLINICAL HISTORY (SUMMARY):

The xx year of age injured worker was documented to have sustained a tibial plateau fracture as part of injuries sustained in a motor vehicle. On MRI of the left knee from 10/28/10, the claimant had a large effusion, severe chondromalacia patella, plateau fracture, some osteochondral defects, joint debris, low grade ACL injury and torn menisci. Denial letters have noted the lack of documentation of failure of non-operative treatment and/or the lack of results of recent imaging studies evidencing adequate fracture healing. AP records were reviewed, including from 12/14/10, showing "no evidence of a residual fracture line." However, neither subjective complaints nor objective physical exam findings were documented on 12/14/10, the most recent date of AP records.

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

Without recent documentation of subjective and objective findings and/or failure of a trial of non-operative treatments such as aspiration, injection and therapy; the claimant has not been evidenced to have a condition that has failed non-operative treatment. Therefore, the proposed procedure (with assistant.) is not medically reasonable or necessary at this time based upon the records reviewed.

Reference: ODG-Knee Chapter

ODG Indications for Surgery -- Diagnostic arthroscopy:

Criteria for diagnostic arthroscopy:

1. Conservative Care: Medications. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS
3. Imaging Clinical Findings: Imaging is inconclusive.

ODG Indications for Surgery-- 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 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.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE &

**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 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)