

# I-Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/29/2011

**IRO CASE #:**

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

Left Knee Arthroscopy

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

M.D. 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**

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates Knee and Leg Chapter, ODG Indications for Surgery| -- Diagnostic arthroscopy

Peer Review Determination Dr.: 04/01/11

Letter of Appeal Dr.: 04/19/11

Peer Review Determination Dr.: 04/27/11

MRI Report Left Knee: 11/10/10

Office Notes Dr.: 10/10/10, 11/02/10, 11/11/10, 12/02/10, 01/07/11 and 01/28/11

Office Notes Dr.: 03/24/11

Physical Therapy Evaluation PT: 12/09/10

Physical Therapy Notes: 12/21/10, 12/28/10, 01/04/11, 01/05/11, 01/07/11, 01/11/11, 01/13/11, 01/14/11, 01/18/11, 01/20/11, 01/25/11, 01/26/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a XX year-old female who injured her left knee at work on XX/XX/XX as a result of a slip and fall twisting the left knee. The current diagnosis is internal derangement of the left knee.

Review of clinical records submitted dated from 10/19/10 to 01/28/11 indicate that the claimant was under the care of Dr.. The claimant presented with ongoing moderate to severe medial pain in the left knee with decreased range of motion. Dr.'s initial impression was that the claimant had torn medial cartilage or meniscus. Dr. ordered x-rays of the left knee, which were essentially negative and an MRI of the left knee which was done on 11/10/10. The MRI of the left knee demonstrated an avulsion injury with a partial fracture at the posterior cruciate ligament insertion on the posterior proximal tibia, a Grade I sprain of the medial collateral ligament, a Grade III chondrosis at the patellar undersurface and a moderate to large left knee effusion with a large Baker's cyst. Dr. treated the claimant conservatively with formal physical therapy, oral anti-inflammatory and analgesic medications, activity modifications and a steroid injection into the left knee, which was done on 01/28/11. Physical therapy notes submitted for review dated 12/09/10 to 01/26/11 indicated that the claimant attended twelve out of twelve authorized therapy sessions with progression to a home exercise program.

The claimant was seen on 03/24/11 by Dr. with continued complaints of moderate to severe left knee pain. Dr.'s examination of the claimant revealed medial joint line tenderness, crepitus, equivocal

McMurray test and a positive patellar grind test. Lachman and drawer tests were negative. Dr. reviewed the claimant's MRI results and noted that the claimant had failed conservative treatment to date. Dr. recommended an arthroscopy.

Request for arthroscopy was denied per peer review on 04/01/11. Dr. appealed the determination in a letter dated 04/19/11, which he documented that the claimant had received an injection into her left knee without any alleviation of her symptoms.

Dr. noted that the claimant had tenderness, swelling, locking and giving out of her left knee along with difficulty in climbing stairs. Dr. noted that the findings on MRI were consistent with traumatic findings and once again requested authorization for the arthroscopy. The second request for an arthroscopy was denied per peer review on 04/27/11.

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

Request for left knee arthroscopy would be considered medically necessary in this case.

According to Official Disability Guidelines, criteria for a diagnostic arthroscopy – first, conservative care should be rendered in the form of medications or physical therapy. This has been satisfied in this case. There should be subjective clinical findings of pain and functional limitations despite conservative care. This is present in this case. Lastly, imaging and clinical findings should be inconclusive – this is also present in this case. The MRI in this case has demonstrated an avulsion injury of the posterior cruciate ligament, a grade I sprain at the medial collateral ligament, chondrosis of the patellar undersurface and a moderate to large left knee effusion and a large Baker's cyst. This claimant has continued to have mechanical symptoms, pain and swelling. There is medial joint line tenderness present on physical examination. While these types of symptoms would seem to be related to a medial meniscal tear or arthritic problem affecting the medial compartment, none of this has been documented by the MRI. Therefore, and based upon the ODG indications for surgery being satisfied, the reviewer finds that left knee arthroscopy is medically necessary for this patient.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates Knee and Leg 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  
(Washington, 2003) (Lee, 2004)

**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)