

# I-Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Mar/22/2011

**IRO CASE #:**

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

Outpatient left knee arthroscopy with medial meniscectomy

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

ODG, Knee and Leg Chapter  
Dr.: 12/15/10, 01/12/11  
MRI report: 01/07/11  
Peer Reviews: 01/31/11, 02/18/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who sustained a work related injury to his left knee when he twisted his knee and developed a little bit of swelling. When he saw Dr. on 12/15/10 the claimant stated he had been having pain for about 2-3 weeks. The claimant stated that when he twisted his knee he developed a bit of a pop and developed pain and a little stiffness. On examination the claimant had mild effusion in his left knee. He had full extension and flexion to 120 degrees. His Lachman's test and his anterior and posterior drawer tests were negative. His collateral ligaments were intact. He had a positive McMurray's testing with pain at the medial joint line. X-rays of the claimant's left knee taken in standing AP and lateral and merchant views on 12/15/10 showed no obvious fracture, no osteophytes and no significant arthritic changes. Dr. recommended an MRI of the left knee, which was done on 01/07/11 and showed marked degenerative joint disease of the medial compartment. There was an abnormal position and signal of the medial meniscus with concern for an extensive horizontal tear. There was a small joint effusion, which suggested a reactive synovitis. When the claimant saw Dr. on 01/12/11 Dr. recommended an arthroscopic medial meniscectomy. There was no mention of any conservative treatment such as a steroid injection, anti-inflammatory medications or physical therapy. This request was noncertified by two peer reviews. The first peer review dated 01/31/11 noncertified the meniscectomy as documentation did not mention what conservative treatment had been provided such as physical therapy, knee injections. Given the presence of significant arthritis of the knee and relative lack of mechanical symptoms, the doctor felt it would appear prudent to exhaust conservative treatment prior to surgery. The second peer review dated 02/08/11 also

noncertified the surgery as there was no mention of any conservative treatment and the claimant had no mechanical symptoms.

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

The reviewer finds no medical necessity for Outpatient left knee arthroscopy with medial meniscectomy. Based on the Official Disability Guidelines, meniscectomy is an option if conservative measures have been employed such as physical therapy, medications, or activity modification. This information is lacking in this case; there are no forms of conservative treatment documented and the records do not reflect a blocked or locked knee. In light of the absence of conservative treatment, the procedure could not be approved, based on the information provided.

**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)