

SENT VIA EMAIL OR FAX ON
Sep/08/2011

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Knee Scope / Partial Meniscectomy / Partial Lateral Meniscectomy

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Preauthorization request determination / UR denial 08/12/11
2. Preauthorization review reconsideration of adverse determination / UR reconsideration upheld 08/22/11
3. Office notes M.D.
4. Handwritten progress record
5. Left knee MRI 08/01/11
6. Orthopedic history, patient registration 01/09/08
7. Worker's comp worksheet 08/05/11
8. Emergency department records 07/21/11
9. Progress note 07/26/11 M.D.

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xxxx. Records indicate the patient reported knee pain after slipping on wet surface and twisting his knee laterally. The patient is noted to have history of previous knee surgery with ACL reconstruction in 2007. The patient was seen in emergency department on 07/21/11, and x-rays revealed no acute fracture of left knee. The injured employee was treated conservatively with application of knee immobilizer. MRI of the left knee performed 08/01/11 revealed prior anterior cruciate ligament repair with normal signal of tendon graft. There was partial tear or trimming of anterior aspect of medial meniscus. There was a tear or trimming of apex of mid portion of lateral meniscus. The patient was seen in consultation by Dr. on 08/08/11. The claimant reports he cannot walk

without knee immobilizer. There is tenderness to palpation at medial and lateral joint line. A small effusion was noted. The claimant has pain with range of motion. He is neurovascularly intact. Exam is otherwise negative. The claimant was recommended to undergo left knee arthroscopy with partial medial meniscectomy and partial lateral meniscectomy.

A request for authorization of left knee scope / partial meniscectomy / partial lateral meniscectomy was reviewed on 08/12/11 and determined the request does not meet medical necessity guidelines. The reviewer noted the injury occurred less than one month ago. The claimant has a history of prior ACL reconstruction, but the date of surgery was not documented. There was no documentation of conservative treatment for the left knee other than knee immobilizer. On examination there was no indication of positive McMurray's. Range of motion measurements was not reported. As such, medical necessity was not established.

A request for reconsideration of adverse determination was reviewed on 08/22/11 and the reconsideration request for left knee arthroscopy, partial medial meniscectomy, and partial lateral meniscectomy was determined to not meet medical necessity guidelines. The reviewer noted that ODG Guidelines on meniscectomy outline indications for meniscectomy surgery which include documentation of conservative treatment including physical therapy, medications, and activity modifications. There should be subjective findings of mechanical symptoms such as swelling, giving way, locking, clicking or popping. Physical examination should include mechanical findings such as positive McMurray's sign, joint line tenderness, effusion, limited range of motion, locking, clicking, popping, or crepitus as well as MRI indicating meniscal tear. In the claimant's case the results of MRI are not clear for acute medial or lateral meniscal tear. The radiologist indicated changes possibly related to trimming from the claimant's previous surgery. Additionally, the symptomatology while revealing swelling does not indicate any other mechanical symptoms such as popping, clicking, or giving way. Physical examination was nonspecific and revealed no objective evidence of mechanical findings consistent with medial or lateral meniscal tear. Finally, the claimant has had no documented conservative treatment other than knee immobilizer. Based on the above, the request for left knee arthroscopy with partial medial and lateral meniscectomy cannot be considered medically necessary, and the request is denied.

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

The clinical data presented for review does not establish medical necessity for left knee scope with partial medial and lateral meniscectomies. The claimant is noted to have sustained an injury when he slipped on wet surface and twisted his knee laterally. He was seen in emergency department at which time a knee immobilizer was applied. X-rays at that time revealed no acute fractures. The records reflect the claimant has history of previous ACL reconstruction performed in 2007. MRI of left knee on 08/01/11 revealed postoperative changes with prior ACL repair. There was evidence of partial tear or trimming of anterior aspect of medial meniscus and tear or trimming of apex of mid portion of lateral meniscus. No operative report of the prior ACL surgery was submitted for review. The injured employee had tenderness to palpation at the medial and lateral joint line with small effusion, and pain with range of motion. However, there was no documentation of positive McMurray's, Apley's, or other orthopedic testing. Range of motion measurements were not provided. Other than the knee immobilizer provided at emergency department, there is no indication the claimant has had any conservative treatment for left knee. As such, the proposed surgical procedure is not indicated as medically necessary. The previous denials were appropriately rendered and should be upheld on IRO.

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)