



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 8/06/2012

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Post Operative CPM Rental for the Left Knee and Cryotherapy Unit.

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

M.D. Board Certified in Orthopedic Surgery, Sports Medicine Orthopedics.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

(Agree

e) Overturned

(Disag

ree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY:

The patient is a male with a work-related left knee injury sustained on xx/xx/xx. The patient has undergone arthroscopic partial medial meniscectomy with chondroplasty of the medial and lateral femoral condyles, loose body removal, and synovectomy on 11/30/2011. He has had persistent symptoms in the knee despite this intervention as well as post operative physical therapy, corticosteroid injection, and Euflexxa series. It seems this led to the recommendation to perform a L knee hemiarthroplasty. It is unclear from the provided documentation if this is actually planned at this point.

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



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Per ODG references and based on the records submitted for review the request for post operative CPM rental and cryotherapy unit is not medically necessary.

It is unclear from the provided documentation whether the request for the water circulating cold pad and pump is for a post surgical use or not. Regardless, there is not a medical necessity for the device. If it is not for post surgical use, then there is no evidence to support use of a cold pad for nonoperative use. If it is for post surgical, use there is insufficient evidence to support that a water circulating cold pad is superior to other forms of cold therapy such as ice packs for pain control or early functional improvements. The prior denials for this should be upheld as this device is not medically necessary.

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
- 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