

IRO REVIEWER REPORT TEMPLATE -WC



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Notice of Independent Review Decision

Date Sent to All Parties: 12/19/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPT code 29870, 29888, 29881, 29999, 29876, 29884 for right knee arthroscopy, ACL repair, Lateral meniscectomy, lateral meniscus repair, synovectomy and excision/lysis

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

Board Certified, Texas Licensed, 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)

Provide a description of the review outcome that clearly states whether medical

necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The treating provider's records were reviewed in detail. These were noted to include the most recent records. The records were specifically noted to be from dated xxxx. There was a consideration for arthroscopy and repair for possible medial meniscal tear and lateral meniscal and persisting symptoms. In fact the findings from were noted to include on exam consistent with "ACL and medial and lateral meniscus abnormalities. Similar to previous symptoms. ACL laxity. Tender lateral meniscus, plus-minus medial meniscal tenderness." There was limited range of motion of the affected right knee. The local point tenderness at the menisci/joint line was noted with positive modified Apley's. The additional prior records from the same facility were also reviewed. It was noted that the claimant had undergone an MRI of the affected right knee. The findings include the MRI of the right knee from 07/31/12. It was noted that the MRI itself revealed a suspected prior injury to the tibial plateau laterally with some osteochondral changes and overall degenerative changes including the anterior horn of the lateral meniscus. There was some early chondromalacia, tricompartmental arthrosis also noted. Additional records revealed that the claimant has undergone conservative treatment including medication and physical therapy and activity restrictions. It was also noted that there was a history of arthroscopic surgery on the same knee. The claimant was considered for the aforementioned arthroscopic surgical intervention. Denial letters have noted the lack of specifically positive findings for ACL tear on exam such as a Lachman or pivot shift and/or drawer sign. In addition through the lack of a torn ACL on MRI, the lack of definitive meniscal tear has also been noted in the denial letters with regards to the MRI dated involved on 07/31/12.

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

OPINION: Uphold denial(s).

RATIONALE: The subjective and objective findings do not at this time meet the ODG guidelines specifically with regards to an ACL tear. There was a lack of sufficient detail evidencing objective findings of an ACL tear as per the ODG guidelines. The guidelines specifically warrant documentation of a positive Lachman or positive pivot shift or significant positive KT1000 findings, which are not evident in this record. In addition, ACL tear is typically required as part of cooperative findings on MRI especially in such a case in which the clinical findings per the guidelines have not been evidenced within this record. In addition, ODG guidelines support a consideration for at least partial meniscectomy if there are both subjective and objective findings along with a "meniscal tear on MRI." There has not been evidence to be a meniscal tear on MRI. Overall, therefore the ODG criteria has not been met at this time and despite the reported failure of nonoperative treatments overall guidelines to date have not been met based on the aggregate of the lack of consistent and/or detailed objective findings clinically and/or on MRI scan.

REFERENCE: ODG guidelines, knee chapter.

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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 (PROVIDE A DESCRIPTION)