

# True Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/09/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right knee arthroscopy with chondroplasty

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO 06/28/12

Utilization review determination 05/24/12

Utilization review determination 06/15/12

MRI right knee 03/15/12

Clinic note Dr. 04/10/12

Clinic note Dr. 04/30/12 and 05/14/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who is reported to have sustained work related injuries to his right knee on xx/xx/xx. He is reported to have been doing training with the when an appliance hit his knee. He reports feeling a pop the following day. His knee was extremely swollen. His pain radiates up and down his leg. Records indicate that the claimant was referred for MRI of the right knee on 03/15/12. This study notes a 5mm focal area of grade 3/4 chondromalacia along the medial femoral trochlea under the apex with underlying reactive bone marrow edema. There is a trace joint effusion and trace Baker cyst. The remaining structures are unremarkable. On 04/13/12 the claimant was seen in follow-up by Dr.. The claimant is reported to be diagnosed with a right knee contusion. He is 70% improved. He is performing light duty. He is not on any current medications. His pain level is reported to be 5/10. The claimant is noted to have a mildly antalgic gait. He has normal flexion and extension but has pain during range of motion testing. He has tenderness over the medial knee area. He was referred to Dr., an orthopedic surgeon, at the claimant's request.

On 04/30/12 the claimant was initially evaluated by Dr.. The claimant reports swelling, limping, clicking, and popping of the knee. His past surgical history includes a right knee arthroscopy with meniscectomy. On physical examination he is 76 inches tall and weighs

190 pounds. He is reported to have an antalgic gait, normal alignment, no effusion, and negative patellofemoral grind. He has full active and passive range of motion with no substantive findings on orthopedic testing. He was ultimately diagnosed with medial trochlea chondromalacia and provided corticosteroid injection. The claimant was continued on light duty.

On 05/14/12 the claimant was seen in follow-up by Dr. He reports that the injection helped with his pain for the first 24 hours and his sense of his pain level has remained unchanged. His physical examination is unchanged.

The initial review was performed on 05/22/12. The reviewer non-certified the request noting that the medical documentation provided for review indicates that the claimant has not exhausted all lower levels of conservative care to include medication or physical therapy. He notes that there are complaints of joint pain but no complaints of swelling with no objective findings such as an effusion, crepitus, or limited range of motion. The reviewer finds that the request does not meet Official Disability Guidelines.

The appeal request was reviewed on 06/15/12. The reviewer non-certified the appeal request noting that full documentation of conservative treatment including the response from previous corticosteroid injection has not been provided. Physical examination findings and decreased range of motion, effusion, and/or crepitus have not been noted. On physical examination the reviewer notes that the documentation of the conservative treatment including response to the six sessions of physical therapy performed has not been provided. He therefore finds that the claimant does not meet guidelines.

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

The request for right knee arthroscopy with chondroplasty is not supported under the Official Disability Guidelines. The record fails to provide adequate information regarding the use of oral medications and the exhaustion of physical therapy. The record notes that the claimant has been referred for therapy. However, response is not documented in the clinical record. Additionally, on examination there are no findings of swelling, crepitus, or limited range of motion and as such the claimant would not meet criteria per Official Disability Guidelines and therefore the prior utilization review determinations are upheld.

**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)