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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/05/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient right knee arthroscopy

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

M.D., Board Certified 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

Official Disability Guidelines

Request for IRO dated 05/18/12

Utilization review determination dated 03/14/12

Utilization review determination dated 03/30/12

MRI right knee dated 01/26/12

Radiographic report right knee dated 01/04/12

Clinic note Dr. dated 02/20/12 and 03/19/12

Peer review Dr. dated 03/14/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a work related injury to his right knee on xx/xx/xx. He felt a pop in his right knee while teaching jump rope. This was followed by acute pain and swelling. He was referred for MRI of right knee on 01/26/12. This study notes horizontal nondisplaced tear in posterior horn of medial meniscus with moderate degenerative joint disease manifested by loss of height and strength of osteochondral surface segment. There is patellofemoral spurring and periarticular marginal spurring. There is minimal subarticular marrow edema. There is mild edema within the cruciate ligament suggesting strain, but no evidence of tear. Lateral meniscus is normal. On 02/20/12 the claimant was examined by Dr. . It is noted the claimant has activity-related discomfort and intermittent swelling. He has no prior history of right knee troubles. He has been treated with sleeve. He has obvious discomfort with squatting maneuver. He has tenderness over the medial greater than lateral joint line. McMurray's is positive for medial sided knee pain. Right knee arthroscopy was recommended. The record includes a peer review from Dr. dated 03/14/12. Dr. opines compensable injury is medial meniscus tear and right knee strain. On 03/19/12 the claimant was reported to have undergone right knee arthroscopy on 03/13/12. Intraoperative findings included tear involving posterior horn of medial meniscus extending from free edge and

meniscus of synovial junction. A partial medial meniscectomy was performed and chondroplasty of trochlea for grade III chondromalacia.

On 03/14/12 an initial review was performed by Dr.. Dr. performed a peer to peer with Dr. and notes that the claimant's treatment has consisted of a knee brace and Tramadol. Prior to this visit he notes that the injury is less than three months old and that the guidelines recommend meniscectomy for patients who have completed conservative care. He notes that the record provided does not indicate that the patient has utilized any conservative care measures to include physical therapy or activity modification. He notes that there is no indication that the claimant has any limited range of motion, locking, clicking, or crepitus.

The subsequent appeal request was reviewed by Dr.. Dr. non-certified the request noting that there must be a failure of conservative management to include physical therapy, medications, or activity modification with at least two subjective and objective clinical findings along with positive imaging findings. He notes that there is a lack of data establishing that the claimant was treated conservatively as there was no physical therapy notes submitted for review.

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

The submitted clinical records indicate that the claimant sustained an injury to the right knee as a result of attempting to instruct a student on how to jump rope. The imaging studies indicate that the injury was of sufficient force to result in abnormal signal in the anterior cruciate ligaments with identification of a horizontal non-displaced tear of the posterior horn of the medial meniscus. Per the letter of appeal as submitted by Dr., there was significant intraarticular pathology and the performance of arthroscopy would be considered the standard of care. Conservative care including a medication regimen of Ibuprofen and Tramadol and sleeve were prescribed. Letter from Dr. states in his peer review that "Treatment including ibuprofen, Tramadol, therapy, MRI, office visits and recommended arthroscopy are medically reasonable as stated by the ODG." As previous reviewers have noted, there were no physical therapy notes submitted for review. However, the ODG indications for surgery state there should be conservative care to include physical therapy OR medication OR activity modification. The patient has utilized medications and neoprene sleeve according to the notes, so this criteria is satisfied. The patient has subjective clinical findings including joint pain and swelling, so this criteria is met. The patient has objective clinical findings including Positive McMurray's sign and joint line tenderness, so this criteria is met. The patient has imaging clinical findings of horizontal non-displaced tear of the posterior horn of the medial meniscus, so this criteria is met. ODG indications for surgery are met. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. The reviewer finds there is medical necessity for Outpatient right knee arthroscopy.

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)