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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Knee Arthroscopy with possible MM repair

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 04/12/12

Utilization review determination dated 02/08/12

Utilization review determination dated 03/15/12

Clinic note Dr. 09/06/11, 12/12/11

MRI left knee 10/03/11

Clinic notes Dr. dated 11/07/11-03/30/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have date of injury of xx/xx/xx. He has a previous injury with surgery to knee. On 09/06/11 the claimant was seen by Dr.. On the day he was injured, he was stepping out of the way of a falling box and twisted his knee. He has no catching or popping and no pain. Pain is located in medial aspect of medial meniscus. Physical examination indicates mild edema of knee, normal gait, mild pain to palpation of medial joint line, negative McMurray's test. He was initially diagnosed with sprain strain, provided oral medications, and referred for physical therapy. On 10/03/11 the claimant was referred for MRI of left knee. This study notes increased signal in posterior horn of medial meniscus probably due to degeneration, no definite meniscal tear is identified. Remainder of study is unremarkable.

On 11/07/11 the claimant was referred to Dr.. The patient had previous surgery to the left knee. Since that time he had been doing well. Current medications include Ibuprofen and Vicodin. Radiographs of left knee demonstrated mild narrowing of medial compartment. On physical examination range of motion is 0-140 degrees. There is mild tenderness in medial femoral condyle and medial joint line. Lachman's is negative. He has no pain with range of motion of hips. Corticosteroid injections were advised. Serial records indicate the claimant

continued to have left knee pain and tenderness along medial joint line despite conservative treatment. Clinic note dated 03/02/12 notes the claimant is pending approval for surgery and notes the claimant has popping, catching and swelling within the knee. On physical examination he continues to have tenderness to medial joint line, pain with McMurray's medially, and Apley's is positive.

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

This claimant has nearly a seven-month history of continuous left knee pain despite conservative management consisting of oral medications, physical therapy and corticosteroid injections.

The imaging studies indicate evidence of increased T2 signal in the posterior horn of the medial meniscus suggestive of degeneration or potentially representing an occult medial meniscal tear. Given that the claimant has not improved with conservative management and continues to have symptoms and given that the most recent physical examinations show a progressive deterioration, the requested surgery is indicated as per the Official Disability Guidelines. The reviewer finds the requested Left Knee Arthroscopy with possible MM repair is medical necessary as per the ODG.

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)