

SENT VIA EMAIL OR FAX ON
May/01/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/30/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right knee diagnostic arthroscopy with partial meniscectomy treatment as indicated and purchase of Cryo unit

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

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)

ODG supports up to 7 days rental of cryotherapy post surgery.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Preauthorization determination 03/13/12

Preauthorization determination 03/26/12

Preauthorization request 03/01/12

Initial orthopedic note 03/01/12

X-rays right knee 2 views 12/29/11

Physical therapy initial evaluation 01/10/12

Progress notes xxxxx 12/29/11-02/15/12 (various providers) Physical therapy

initial visit information 12/30/11

Appeal request 03/19/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male. Records indicate he was delivering packages when his foot slipped stepping out of his truck and twisted his right knee. Per initial orthopedic note dated xx/xx/xx, the claimant had conservative treatment including activity modification, NSAIDs, bracing and steroid injection without substantial improvement. Examination of the right knee revealed exquisite tenderness to posteromedial joint line; markedly positive to medial McMurray's, patellofemoral and lateral joint lines unremarkable; mild body synovitic effusion; no ligamentous insufficiency; no distal swelling; negative Homan's; mild antalgic gait. Right knee x-ray on 12/29/11 was unremarkable. The notes indicate the right knee MRI cannot be obtained due to spinal cord implant. The claimant was recommended to undergo diagnostic arthroscopy with partial meniscectomy and treatment as indicated based on failure to improve with conservative treatment.

A preauthorization determination determined the request for right knee diagnostic arthroscopy with partial meniscectomy and treatment as indicated with purchase of cryo unit to be not medically necessary. It was noted the documentation submitted for review elaborates the claimant complaining of right knee pain. Official Disability Guidelines recommend meniscectomy provided the patient meets specific criteria to include imaging studies confirming the patient's meniscal tear. The x-rays revealed no significant findings. Given the lack of certification regarding the surgery, additional request for cryotherapy unit is rendered non-certified. Given the lack of significant findings confirmed on imaging studies, the request does not meet guideline recommendations.

A reconsideration request for right knee diagnostic arthroscopy with partial meniscectomy and treatment as indicated and purchase of cryo unit was reviewed on 03/26/12 and gain determined as not medically necessary. It was noted that the documentation does mention the claimant having undergone physical therapy, but no end date or number of sessions were included. There was a lack of imaging studies confirming the claimant's meniscal tear. Given the lack of information regarding the patient's completion of conservative treatments and taking into account the lack of imaging studies confirming the meniscal tear, the request does not meet guideline recommendations.

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

The request for right knee diagnostic arthroscopy with partial meniscectomy and treatment as indicated and purchase of cryo unit is supported as medically necessary by the documentation provided for review. The claimant is noted to have slipped and twisted his right knee while delivering packages on 12/29/11. The patient complains of right knee pain. Orthopedic examination on xx/xx/xx revealed the right knee is exquisitely tender in the posteromedial joint line, with markedly positive medial McMurray's. It was noted that MRI of the right knee couldn't be obtained due to spinal cord implant. It was noted that MRI couldn't be performed due to spinal cord stimulator implant; however, physical examination findings are consistent with a meniscal tear. The records indicate that the claimant has been treated conservatively with activity modification, NSAIDs, bracing and steroid injection and has not improved substantially. As such, medical necessity is established for diagnostic arthroscopy with possible partial meniscectomy and treatment as indicated. Consequently, a cryotherapy unit would be indicated post-operatively, but there is no need for purchase as ODG supports up to 7 days of continuous flow cryotherapy. Rental of the device for up to 7 days would be appropriate.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES