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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/11/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: arthroscopy medial meniscectomy LT knee

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified General 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for an arthroscopy medial meniscectomy LT knee is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

X-ray of the left knee dated 02/26/13

Muscle strength exam note dated 01/31/13

Clinical note dated 01/31/13

Muscle strength exam dated 02/28/13

Clinical note dated 02/28/13

X-ray of the left ankle dated 08/20/13

Clinical note dated 08/27/13

X-ray of the left knee dated 08/20/13

MRI of the left knee dated 08/29/13

Therapy evaluation dated 09/03/13

Clinical note dated 09/03/13

Muscle strength exam note dated 09/05/13

Clinical note dated 09/05/13

Clinical note dated 09/10/13

X-ray of the left shoulder dated 09/11/13

Clinical note dated 09/26/13

Adverse determinations dated 09/18/13 & 10/10/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his left knee, left ankle, and shoulder after a slip, trip, and fall. The clinical note dated 01/31/13 indicates the patient complaining of tenderness upon palpation at the left knee. The note indicates the patient having undergone an injection at the right knee. The x-ray of the left knee dated 02/26/13 revealed essentially normal findings. No fracture or dislocation was noted. The clinical note dated 02/28/13 indicates the patient complaining of left knee pain with a locking sensation. The x-rays of the left knee dated 08/20/13 revealed

intraarticular effusion representing post-traumatic synovitis. The clinical note dated 08/27/13 indicated the patient having a positive McMurray's sign at the left knee. Tenderness was noted at the medial joint line with mild crepitus. The MRI of the left knee dated 08/29/13 revealed a horizontal tear of the posterior horn of the medial meniscus. Small joint effusion was noted. The therapy evaluation dated 09/03/13 indicates the patient complaining of left knee pain that was rated as 5-8/10. The patient stated that he was having difficulty with stairs. The patient was able to demonstrate 0-100 degrees of range of motion at the left knee. Strength deficits were noted at the left knee that were rated as 4-/5 with both flexion and extension. The clinical note dated 09/05/13 indicates the patient continuing with medial joint line tenderness at the left knee. The note indicates the patient ambulating with a crutch.

The clinical note dated 09/10/13 indicates the patient utilizing Ibuprofen for ongoing pain relief.

The prior utilization review dated 09/18/13 resulted in a denial for a left knee meniscectomy as no information was submitted for review including orthopedic testing of the left knee and no comprehensive history indicating the nature and extent of the physical therapy completed to date for the patient's left knee complaints.

The utilization review dated 10/10/13 resulted in a denial for a left knee meniscectomy as no information was submitted regarding the patient's subjective complaints confirming meniscal pathology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review notes the patient complaining of left knee pain with associated tenderness at the medial joint line. An arthroscopic meniscectomy would be indicated provided the patient meets specific criteria to include significant clinical findings noted by exam and the patient is noted to have completed all conservative treatments. There is mention in the clinical notes regarding an evaluation for physical therapy; however, it is unclear if the patient has completed a full course of treatment. No information was submitted regarding the patient's specific complaints of the knee giving way, locking, clicking, popping, or ongoing swelling. As such, it is the opinion of this reviewer that the request for an arthroscopy medial meniscectomy LT knee is not recommended as medically necessary.

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)