

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/20/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left knee surgery; ACL reconstruction, ablative chondroplasty

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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. It is the opinion of the reviewer that the request for left knee surgery; ACL reconstruction, ablative chondroplasty is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical note 10/26/12
Clinical note 12/12/12
Clinical note 01/07/13
Clinical note 04/19/13
Clinical note 06/24/13
Clinical note 07/26/13
Clinical note 08/16/13
Clinical note 08/30/13
Clinical note 09/13/13
Clinical note 10/28/13
Adverse determinations 09/20/13 and 10/15/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her left knee as a result of a fall. Clinical note dated 10/26/12 indicated the patient showing swelling and limited range of motion at the left knee. The patient also had complaints of pain at night. Upon exam, 2+ effusion as well as a positive McMurray sign were noted at the left knee. The patient demonstrated 0-110 degrees of range of motion with pain. Tenderness to palpation was noted. Clinical note dated 12/12/12 indicated the patient undergoing conservative treatment and cortisone injections. The patient continued with mechanical symptoms. Clinical note dated 01/07/13 mentioned the patient utilizing ibuprofen with mild relief. Quadriceps tone was decreased. The patient was recommended for surgical management. Clinical note dated 04/19/13 mentioned the patient having 4+ to 5- strength in the quadriceps. Clinical note dated 06/24/13 indicated the patient having 1+ to 2 anterior drawer sign and 1+ to 2+ Lachman. Clinical note dated 07/26/13 mentioned the patient

undergoing cortisone injection with marginal relief for a couple of days. Clinical note dated 08/16/13 mentioned the patient lacking full extension by approximately three to four degrees. Clinical note dated 09/13/13 mentioned the patient rating her pain as 5-6/10. Clinical note dated 10/20/13 mentioned the patient continuing with range of motion and strength deficit. Utilization review dated 09/20/13 resulted in a denial for an ACL reconstruction and chondroplasty as no imaging studies were submitted. Utilization review dated 10/15/13 resulted in denial for surgical intervention as no imaging studies were submitted.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has complaints of left knee pain with associated range of motion deficits. An ACL reconstruction and chondroplasty would be indicated with imaging studies in place confirming pathology. No imaging studies were submitted resulting in confirmation of ACL involvement. Therefore, the request fails to meet the necessary criteria. As such, it is the opinion of the reviewer that the request for left knee surgery; ACL reconstruction, ablative chondroplasty 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)