

Notice of Independent Review Decision

DATE OF REVIEW: 10/01/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Right Knee Arthroscopy/Posterior Cruciate Ligament Reconstruction/Posterolateral Exploration Repair/Lateral Reconstruction 29888, 29889, 27409

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the Outpatient Right Knee Arthroscopy/Posterior Cruciate Ligament Reconstruction/Posterolateral Exploration Repair/Lateral Reconstruction 29888, 29889, 27409 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 09/16/13
- Notification of Adverse Determination letter – 07/26/13
- Notification of Reconsideration Determination letter – 08/30/13, 09/16/13

- Reconsideration letter – 08/21/13
- Report of MRI of the right knee – 01/09/13
- Patient evaluation – 05/20/13 to 06/17/13
- Report of x-ray study of the knee – 05/20/13
- Report of Initial Evaluation/Examination – 01/16/13
- Progress/Treatment Notes – 02/11/13 to 04/11/13
- Report of Re-Evaluation/Examination – 03/18/13
- Discharge Summary – 04/11/13

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related hyperextension injury to the right knee on xx/xx/xx when he stepped off of his truck and landed awkwardly from a four foot height, hyperextending it and going on to the side. An MRI scan of the right knee dated 01/09/13 revealed a less than complete tear of the posterior cruciate ligament (PCL). The patient underwent examination under anesthesia and arthroscopic debridement of the PCL on 03/06/13. He continues to suffer knee pain and is utilizing a brace. The current request is for preauthorization of arthroscopic PCL repair/reconstruction and posterior lateral corner reconstruction.

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

There is insufficient clinical information to justify overturning previous adverse determinations. There is no current evaluation, mechanical symptoms are not described and interference in the activities of daily living is not described. PCL repair reconstruction is a procedure considered “under study, and is not a recommended procedure based on current evidence based medical decision process.

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

- ACOEM- AMERICAN 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)