



Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 03/14/13

IRO CASE #:

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

Texas-licensed M.D., board certified in Orthopedic Surgery

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthrocentesis, aspiration and/or injection; major joint or bursa (eg. shoulder, hip, knee joint, subacromial bursa).

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)

| Primary Diagnosis Code | Service Being Denied | Billing Modifier | Type of Review | Units | Date(s) of Service | Amount Billed | Date of Injury | DWC Claim # | Upheld Overturn |
|------------------------|----------------------|------------------|----------------|-------|--------------------|---------------|----------------|-------------|-----------------|
| | 76942 | | Prosp | | | | 10/22/12 | 949A74601 | Upheld |
| 844.8 | 20610 | | Prosp. | | | | 10/22/12 | 949A74601 | Upheld |

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a xx-year-old male who suffered a hyperextension injury to the left knee on xxxxx. He was felt to have suffered gastroc soleus muscle injury, sprain of the left knee, and possible exacerbation of an otherwise subacute ACL injury. He was treated initially with a knee sleeve, activity modifications, and physical therapy. A recommendation for arthrocentesis and corticosteroid injection under fluoroscopic guidance was denied. It was reconsidered and denied.

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

There is no evidence of osteoarthritic change. The patient has an ACL tear, which is partial and probably subacute. There are no osteoarthritic changes, and the menisci are normal. Transient benefit to be achieved by corticosteroid injection of the knee is not supported except for osteoarthritic change. ACL tears are not pathology for which intraarticular cortisone injections are considered to be of benefit. Prior denials of this request to preauthorize arthrocentesis cortisone injection under fluoroscopic guidance of the left knee were appropriate and should be upheld.

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

INDEPENDENT REVIEW INCORPORATED



- 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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)