



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 03/18/13

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:

Right knee partial medial meniscectomy to include CPT code 29881

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld** (Agree)
 Overtured (Disagree)
 Partially Overtured (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
836.0	29881		Prosp				xxxxxx		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY (SUMMARY):

The injured employee is a xx-year-old female xxxx who suffered an injury in a slip-and-fall on xxxxx. She injured her right knee. She has a past history of injury to this knee in 2004 resulting in a partial posterior cruciate ligament tear and a chondral fracture involving the medial femoral condyle. She was treated with Synvisc and has done well over the past several years as a result of that injury. Subsequent to the fall of xxxxx, the patient has had mild effusion of the right knee. She has been treated for knee pain with activity modification. She has not worn a knee support. A recommendation for arthroscopic medial meniscectomy was made after an MRI scan revealed subtle degenerative changes in the medial meniscus posterior horn without specific evidence of tear. The request to preauthorize arthroscopic partial medial meniscectomy was considered and denied; it was reconsidered and denied.

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

The patient suffers knee pain, mild effusion, tenderness, and a positive McMurray's sign. She has MRI scan evidence of a subtle posterior horn medial meniscus degeneration without displaced tear. There has been treatment only with activity modification. I find no evidence of medication management, injection, or physical therapy. In the absence of any coordinated consistent conservative care prior to initiating a surgical procedure under circumstances other than a locked

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or blocked knee, the prior denials of this request to preauthorize arthroscopic partial medial meniscectomy 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
- 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)