

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left knee arthroscopy with meniscectomy and meniscal repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified Orthopedic 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 the reviewer that the requested left knee arthroscopy with meniscectomy and meniscal repair is not supported as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 01/18/13
Receipt of request for IRO 01/18/13
Utilization review determination 10/31/12
Utilization review determination 01/15/13
Clinical records dated 04/30/12, 08/09/12, 09/20/12, and 01/08/13
Clinical records dated 05/16/12,
MRI of the left knee dated 05/09/12
Designated Doctor Examination dated 12/05/11
Impairment rating dated 12/05/11

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a female who was reported to have a date of injury of xx/xx/xx. On this date, the claimant is reported to have fallen from a chair sustaining an injury to her left knee. She later underwent left knee arthroscopy and meniscectomy/meniscal repair on 08/22/11. MRI of the left knee on 05/09/12 documented a tear of the posterior horn of the medial meniscus with adjacent marrow edema. The claimant underwent 12 sessions of post-operative physical therapy. She later underwent a left knee epidural steroid injection on 04/23/11. Per physical examination dated 04/30/12, there were complaints of left knee pain with positive McMurray, Apley compression test and point tenderness over the medial aspect of the knee. There was full range of motion.

The initial review was performed on 10/31/12. He noted that there was no clinical

documentation of recent treatment of non-steroidal anti-inflammatory or muscle relaxants. He noted that records did not reflect that the claimant had a cortisone injection or recent conservative management into the knee recently and subsequently non-certified the request.

The appeal request was reviewed on 01/15/13 who non-certified the request, noting that the claimant had not undergone any recent conservative treatment failure based on the clinical documentation provided for review. He noted limited findings on physical examination and that there was no evidence of a locked or blocked knee. As such, he non-certified the appeal request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Minimal clinical records were submitted with this request. There is no evidence of recent conservative treatment and the data regarding treatment to date is not adequately documented. Therefore, based upon the submitted clinical information, it is the opinion of the reviewer that the requested left knee arthroscopy with meniscectomy and meniscal repair is not supported as medically necessary under the Official Disability Guidelines.

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)