

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/20/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Knee Arthroscopy with Chondroplasty, also needs to have lateral release

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

Board Certified Orthopedic Surgeon (Joint)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI of the right knee dated 11/15/12

Clinical reports dated 02/01/13 – 04/29/13

Prior reviews dated 04/12/13 & 05/06/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx while kicking a door. The patient reported right knee pain following the injury. MRI studies of the right knee completed on 11/19/12 demonstrated bone marrow edema within the medial aspect of the patella suggesting a possible contusion. There was mild edema of the quadriceps tendon insertion with no evidence of tearing. The ligament structures appeared intact and there was no evidence of meniscal tearing. The articular cartilages appeared intact and there was no evidence of abnormal tracking of the patella. Prior treatment has included the use of physical therapy which provided mild improvements. The patient did undergo a right knee injection on 02/01/13. Follow up on 02/13/13 stated the patient had approximately 50% relief from the injection for 2 days. Per the patient did have a lateralized patella. The patient was recommended for bracing and patellar stabilization. A 2nd injection to the right knee was provided on 04/15/13. Follow up on 04/29/13 stated that the patient continued to have right knee pain despite 2 injections. Physical examination demonstrated full strength in the right knee. There were negative patellar apprehension signs or evidence of instability. There was mild tenderness to the medial joint line.

The request for right knee chondroplasty and lateral release was non-certified by utilization review on 04/12/13 as there was no evidence of a chondral defect on MRI studies as well as lack of documentation regarding the patient's response to knee bracing. There was no evidence of any effusion or limited range of motion of the right knee.

The request was again denied by utilization review on 05/06/13 as there was lack of findings on MRI to support the surgical request.

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

The patient has been seen for ongoing complaints of right knee pain despite the use of bracing, physical therapy, or multiple injections. The patient's most recent physical examination findings demonstrated no significant abnormal patellar tracking or patellar apprehension signs. There was no patellar hypermobility noted. Imaging studies also did not identify any evidence of chondral defects or a lateral track of the patella. Given the absence of objective findings on the most recent physical examination and as the MRI study of the right knee was essentially unremarkable for any chondral defects or a lateralized patella; the surgical request would not be consistent with guideline recommendations. As such, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

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)