

I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste 117-501
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: arthroscopy with treatment of intraarticular pathology for the right knee

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. 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 request for an arthroscopy with treatment of intraarticular pathology for the right knee is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes dated 02/28/13 – 04/23/13
MRI of the right knee dated 04/09/13
Previous utilization reviews dated 05/15/13 & 05/28/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his right knee when he was attempting to load material onto a long conveyor belt. The patient stated that when he turned to the right side to activate the kicker arm switch, he experienced pain in the right knee. The clinical note dated xx/xx/xx details the patient demonstrating tenderness upon palpation at the lateral joint line. The patient rated his right knee pain as 5/10. The patient reported significant pain along the lateral joint line. The MRI of the right knee dated 04/09/13 revealed full thickness chondral fissuring of the central femoral trochlea. Mild popliteus tendinosis was also noted. The clinical note dated 04/23/13 details the patient continuing with right knee pain. The patient also noted locking of the knee as well as range of motion restrictions. The patient was able to demonstrate 0 to 135 degrees of right knee range of motion. Extreme flexion was noted to cause pain in the patella femoral region. The note does detail the patient utilizing pain medications. The patient was further noted to have returned to work with restrictions.

The utilization review dated 05/15/13 resulted in a denial for a right knee arthroscopy secondary to no information being provided regarding the patient's conservative therapy or injection history.

The utilization review dated 05/28/13 resulted in a denial for a right knee arthroscopy secondary to the patient lacking any information regarding completion of all conservative

measures to include physical therapy and injections.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of right knee pain. A knee arthroscopy would be indicated provided the patient meets specific criteria to include imaging studies revealing inconclusive findings and the patient is noted to have completed all conservative measures. No information was submitted regarding the patient's previous involvement with conservative therapies. Additionally, it is unclear if the patient underwent any injections at the right knee. Furthermore, the submitted imaging studies confirm a fissuring at the central femoral trochlea. Given that no information was submitted regarding the patient's completion of all conservative measures and taking into account the conclusive findings revealed on the submitted imaging studies, this request is not indicated. As such, it is the opinion of the reviewer that the request for an arthroscopy with treatment of intraarticular pathology for the right knee is not recommended as medically necessary.

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)