

Applied Assessments LLC

An Independent Review Organization
3005 South Lamar Blvd, Ste. D109 #410

Austin, TX 78704

Phone: (512) 772-1863

Fax: (512) 857-1245

Email: manager@applied-assessments.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Knee Arthroscopy with Possible Chondroplasty and Arthrotomy

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Operative report 01/16/12

Procedure note 01/17/12

Operative note 01/19/12

Clinical notes 02/03/12-05/06/13

Operative note 02/01/13

MRI right knee 04/29/13

Previous utilization review RME 06/21/13

Previous utilization review 05/13/13 and 06/12/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his right lower extremity when he was involved in a motor vehicle accident. The patient sustained a fractured right femur and ankle with subsequent knee pain and a rib fracture and head laceration with a closed head injury. Operative report dated 01/16/12 detailed the patient undergoing incision and debridement of the right thigh wound with placement of a femoral traction pin. Procedure note dated 01/17/12 detailed the patient undergoing traction pin removal with an IND of the open fracture down to the bone and then a subsequent intermedullary nail fixation at the right femoral shaft fracture. Operative report dated 01/19/12 detailed the patient undergoing an ORIF of the right medial malleolus. Clinical note dated 02/03/12 detailed the patient continuing with non-weight bearing status. The patient was fitted for bone growth stimulator. The patient was also utilizing a cam boot. The patient was subsequently diagnosed with a DVT in the right

lower extremity. Operative report dated 02/01/13 detailed the patient undergoing hardware removal of the right femoral intermedullary pin. Clinical note dated 02/13/13 detailed the patient presenting for follow up and subsequent suture removal. The patient continued with Ultram for ongoing pain relief. Clinical note dated 04/17/13 detailed the patient complaining of right knee pain with no significant improvement. The patient was recommended for MRI of the right knee. The patient had specific complaints of weakness in the right thigh and sharp pain at the medial aspect of the patella. MRI of the right knee dated 04/29/13 revealed a focal osteochondral defect on the medial tibial plateau with no obvious loose bodies. Clinical note dated 05/06/13 revealed minimal tenderness over the medial joint line. The patient had an audible pop with tibial rotation. Clinical note dated 06/21/13 detailed the patient continuing with right knee pain. Previous utilization review dated 05/13/13 detailed for a right knee arthroscopy with possible chondroplasty and arthrotomy resulted in denial secondary to a lack of information confirming completion of all conservative measures. Previous utilization review dated 06/12/13 resulted in denial for services secondary to a lack of information regarding completion of all conservative treatment and significant findings indicating swelling at the right knee.

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

Clinical documentation submitted for review notes the patient complaining of right knee pain at the medial portion with associated tenderness at the medial area region. Arthroscopic chondroplasty and arthrotomy would be indicated provided that the patient meets specific criteria, including completion of all conservative treatment and significant findings indicating swelling and effusion. There is information regarding the use of Ultram for ongoing pain relief. However, no information was submitted regarding completion of any conservative treatment or of significant swelling or effusion at the right knee. Given this the request is not indicated as medically necessary. As such it is the opinion of this reviewer that the services including chondroplasty and arthroscopic chondroplasty are not recommended as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES