



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 9/25/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right knee Arthroscopy/ partial medial Menisectomy/ Chondroplasty

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

M.D. Board Certified in Orthopedic Surgery and Sports Medicine Orthopedic.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Department of Insurance Notice of Case Assignment	9/05/2013
Workers' Compensation Services Notifications of Reconsideration Determinations	8/06/2013-8/27/2013
Progress Reports	7/15/2013-8/02/2013
Radiology Report	5/30/2013

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female with date of injury of xx/xx/xx. She sustained a fall onto her right knee while walking down an incline. Per her clinical notes, she has had persistent pain in the medial knee since that time with antalgic gait, popping, giving way and loss of motion. Her physical exam demonstrated morbid obesity with antalgic gait pattern. There is noted to be loss of motion in both flexion and extension with an arc of motion from 10-100 degrees of flexion. There is noted tenderness at the medial joint line and positive McMurray's and Apley's tests. There is an effusion present. No ligamentous instability is noted. There is patellar crepitus. MRI findings include edema in the vastus medialis oblique muscle consistent with a contusion or low grade muscle strain, degenerative signal in the posterior medial meniscus without evidence of a tear, and mild generalized patellar chondromalacia. Documented treatment to this point includes an intra-articular steroid injection that provided only 48 hours



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of relief from pain, icing, and use of a knee sleeve. The patient had shown no change in her status at her last follow up on 8/2/2013 other than a cold burn type injury in the medial knee.

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

Per ODG references, the requested services "Right knee arthroscopy/ partial medial Meniscectomy/ Chondroplasty" are not medically necessary. The patient clinically demonstrates signs and symptoms consistent with a medial meniscal tear but there is no MRI evidence to support this. She also has no documentation of formal physical therapy or medical management with use of prescription NSAIDs. In light of the lack of exhausting conservative options, and the lack of objective MRI evidence of a medial meniscal tear, the requested surgical procedure is not approved.

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 KNOWLEDGE BASE
- 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