

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/17/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Knee Diagnostic Arthroscopic with Possible Chondroplasty and Synovectomy, as an Outpatient between 8/23/2013 and 10/22/2013

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

Therapy note dated 12/12/12

MRI of the left knee dated 09/25/12

Radiology report dated 05/16/13

Clinical note dated 03/28/13

Clinical note dated 04/18/13

Clinical note dated 05/23/13

Clinical note dated 08/13/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury regarding her left knee from an unknown origin. The MRI of the left knee dated 09/25/12 revealed an oblique tear of the posterior horn of the medial meniscus. The therapy note dated 12/12/12 indicates the patient having completed 8 physical therapy sessions to date. The radiology report dated 05/16/13 revealed no evidence of a meniscal tear. Degenerative signal was noted in the body and posterior horn. Mild truncation of the inner free edge of the body segment of the lateral meniscus was noted. The clinical note dated 03/28/13 indicates the patient having previously undergone a left knee arthroscopic partial lateral meniscectomy. The patient continued with 4/10 pain at that time. The note mentions the patient utilizing Vicodin for ongoing pain relief. The patient was noted to have undergone a Lidocaine and Depomedrol injection at that time. The clinical note dated 04/18/13 indicates the patient rating the left knee pain as 3-8/10. Upon exam, the

patient was able to demonstrate full range of motion at the left knee at that time. The clinical note dated 05/23/13 indicates the patient continuing with 6/10 pain. The clinical note dated 08/13/13 indicates the patient being recommended for a diagnostic arthroscopy with a possible chondroplasty and synovectomy at the left knee.

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 left knee pain. A diagnostic arthroscopy would be indicated at the knee provided the patient meets specific criteria to include completion of all conservative measures. No information was submitted regarding the patient's previous completion of any conservative therapies addressing the left knee complaints. As such, it is the opinion of this reviewer that the request for a left knee diagnostic arthroscopy with a possible chondroplasty and synovectomy as an outpatient between 08/23/13 and 10/22/13 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)