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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/14/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left knee scope w/menisectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgeon

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 a left knee scope w/menisectomy is recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes dated 06/13/13, 07/31/13, & 09/11/13

MRI report dated 06/19/13

Therapy notes dated 06/27/13, 07/09/13, 07/11/13, 07/16/13, 07/18/13, 07/23/13, 07/25/13, 07/30/13, 08/01/13, & 08/06/13

Previous adverse determinations dated 08/13/13 & 09/03/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his left knee. The clinical note dated 06/13/13 mentions the patient having increased pain particularly with walking, and a popping and clicking sensation at the left knee. The MRI of the left knee dated 06/19/13 revealed a horizontal oblique tear at the posterior horn of the medial meniscus and the posterior horn of the lateral meniscus which was noted to intersect the inferior articular surface of the respective menisci. Minimal edematous changes were noted at the distal ACL and the proximal MCL without disruption. A small 5 x 6mm osteochondral defect was noted within the subarticular lateral tibial condyle. The clinical note dated 07/31/13 indicates the patient continuing with left knee pain that was described as a sharp feeling. Radiating pain was noted into the hip when walking. The note does mention the patient utilizing Vytarin. The patient was recommended for an arthroscopic meniscectomy at that time. The therapy note dated 08/06/13 indicates the patient having completed 10 physical therapy sessions to date. The clinical note dated 09/11/13 mentions the patient stating that previous therapy had exacerbated the pain. The note does mention the patient utilizing Norco for ongoing pain relief.

The previous utilization review dated 08/13/13 resulted in a denial for a left knee scope with meniscectomy secondary to documentation of physical therapy had not been exhausted at that time.

The utilization review dated 09/03/13 resulted in a denial for a left knee scope with meniscectomy as clinical findings indicating a positive McMurray's sign were not noted upon exam and range of motion limitations were not noted in the documentation.

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. An arthroscopic meniscectomy would be indicated provided the patient meets specific criteria to include completion of all conservative therapies; the patient is noted to have significant clinical findings, and imaging studies confirm the patient's meniscal involvement. The documentation does detail the patient having a positive McMurray's sign. Additionally, the patient is noted to have completed a full course of physical therapy addressing the left knee complaints. Furthermore, the previously completed imaging studies confirm medial and lateral meniscus tears. Given the significant clinical findings noted by exam and taking into account the patient's completion of a full course of conservative treatments as well as imaging studies confirming the patient's meniscal tear, this request is reasonable. As such, it is the opinion of the reviewer that the request for a left knee scope w/menisectomy is 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)