

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/30/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right knee medial meniscectomy

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 this reviewer that the request for a right knee medial meniscectomy is not recommended as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical note 03/13/13

MRI right knee 04/15/13

Clinical note 05/22/13

Clinical note 06/12/13

Clinical note 07/31/13

Letter of appeal 08/09/13

Adverse determination 06/05/13 and 07/09/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her right knee. Clinical note dated 03/13/13 detailed the patient stating that the initial injury occurred when she stepped on a transport vehicle and felt a pop in the right side of her right knee. The patient noted significant pain which was exacerbated by ambulation. Pain was located at the front and back of the knee. No medial or lateral pain was noted at that time. Upon exam the patient demonstrated full extension. Tenderness was noted at the fat pad medially and laterally. MRI of the right knee dated 04/15/13 revealed minimal joint effusion. Grade 3 tear was noted at the tibial attachment of the posterior horn of the medial meniscus. Mild to moderate degenerative joint disease was also noted at the anterior medial joint compartments. Clinical note dated 05/22/13 detailed the patient continuing with right knee pain. Upon exam the patient had positive McMurray sign and positive Steinman test. Pain was also elicited with hyperflexion of the knee. Clinical note dated 06/12/13 detailed the patient continuing with positive McMurray sign. The patient had crepitus noted by exam. Clinical note dated 07/31/13 detailed the patient describing a twisting-type injury. The letter of appeal dated 08/09/13 detailed the patient being recommended for surgical intervention.

Previous utilization review dated 07/09/13 for a right knee medial meniscectomy resulted in a

denial secondary to the patient not undergoing full course of conservative treatment including physical therapy, mobilization, and injection therapy.

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. A meniscectomy would be indicated provided that the patient meets specific criteria, including completion of all conservative measures. No information was submitted regarding completion of a full course of physical therapy addressing right knee complaints or activity modification including immobilization or the use of crutches. Given this the request is not indicated. As such, the clinical documentation provided for review does not support this request at this time. As such it is the opinion of this reviewer that the request for a right knee medial meniscectomy 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)