

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/27/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** arthroscopy right knee with 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 arthroscopy right knee with meniscectomy is recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who initially presented with complaints of right knee pain. The MRI of the right knee dated 07/28/14 revealed a subtle subcortical insufficiency fracture at the medial aspect of the medial femoral condyle with underlying marrow edema. An irregular degenerative tear was identified at the posterior horn and body of the medial meniscus. Degenerative osteonecrosis was identified at the patella femoral compartment. A 2 x 2.5 x 2cm multiloculated ganglion was revealed at the posterior to the medial distal femoral diaphysis. The clinical note dated 08/07/14 indicates the patient complaining of right knee pain after a twist and fall at work. The patient had twisted his knee resulting in significant pain. The patient reported significant swelling and pain since the initial injury. Upon exam, moderate swelling was identified at the knee with tenderness over the medial joint line and a grossly positive medial McMurray's. A popping sensation was also revealed posterolaterally. The therapy note dated 10/01/14 indicates the patient continuing with complaints of 4-5/10 pain. The patient has completed 5 physical therapy sessions to date.

The utilization review dated 08/08/14 resulted in a denial as no record of conservative treatments had been submitted.

The utilization review dated 09/05/14 resulted in a denial as no information had been submitted regarding the patient's mechanical symptoms as well as the lack of information regarding the patient's conservative care.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient complaining of right knee pain. The therapy notes do indicate the patient demonstrating significant functional deficits to include 4/5 strength with both right knee flexion and extension. There was also an indication the patient is demonstrating 0-130 degrees of range of motion at the right knee. The MRI of the right knee revealed an irregular degenerative tear at the posterior horn and body of the medial meniscus. Provocative testing indicated a positive McMurray's sign at the medial joint line. There is an indication the patient had initiated therapy addressing the right knee complaints. Given these factors, the requested right knee arthroscopic meniscectomy is indicated as medically necessary. As such, it is the opinion of this reviewer that the request for arthroscopy right knee with meniscectomy is recommended as medically necessary. The prior denials are overturned.

**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)