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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/30/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left knee EUA, arthroscopy, excision meniscus tear

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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 Left knee EUA, arthroscopy, excision meniscus tear is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his left knee when he suffered a twisting type injury with an immediate onset of pain on xx/xx/xx. The MRI of the left knee dated 11/21/13 revealed a horizontal oblique tear of the posterior horn of the medial meniscus as well as mild chondromalacia at the patella and medial compartment. The clinical note dated 12/06/13 indicates the patient able to demonstrate 5 to 120 degrees of range of motion at the left knee. Pain was identified at the medial joint line. The patient was also identified as having a positive McMurray's sign. The clinical note dated 04/28/14 indicates the patient continuing with left knee pain. The patient described severe levels of pain while ambulating. The patient also stated that he was having difficulty fully extending the leg. The note indicates the patient utilizing a hinged knee brace. The patient also was identified as having 10 to 85 degrees of range of motion at that time. The clinical note dated 05/19/14 indicates the patient opting for no surgery at that time. There is an indication the patient is having episodes of locking at that time. The patient continued with 10 to 85 degrees of range of motion. A notable limp was identified when ambulating. The patient has been utilizing Norco for pain relief.

The utilization review dated 05/02/14 resulted in a denial as no information had been submitted regarding the patient's completion of any conservative care.

The utilization review dated 06/18/14 indicates the patient having initiated physical therapy. However, no information was submitted regarding the frequency or duration as well as the completion of a full course of treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of left knee pain with associated range of motion deficits. The submitted MRI revealed a meniscal tear along with significant findings of chondromalacia. Therefore, it does appear that the patient may benefit from a surgical procedure. However, no information was submitted regarding the patient's previous completion of any conservative treatments addressing the left knee complaints. Therefore, the operative procedure is not full indicated for this patient at this time. As such, it is the opinion of this reviewer that the request for a Left knee EUA, arthroscopy, excision meniscus tear 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)