

IRO Express Inc.

An Independent Review Organization

2131 N. Collins, #433409

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/04/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right knee arthroscopy, lateral meniscectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient developed complaints of right knee pain with associated weakness. The patient's history was pertinent for a prior arthroscopy. The patient did describe swelling and weakness without locking or catching. The patient was seen on 04/09/14. No conservative treatment was discussed. Physical examination noted negative McMurray's and Apley's signs. The patient did have pain at 30 degrees with varus and valgus stress testing. 1+ effusion was noted. Radiographs were stated to show some developmental varus on standing AP. No degenerative changes were noted. It appears that the patient did have a previous microfracture procedure for the right knee. MRI studies were recommended and performed on 04/12/14. The study showed a small 15mm region of edema in the anterior medial aspect of the medial femoral condyle consistent with a bone contusion. There was a horizontal tear of the anterior horn of the lateral meniscus. It is unclear if this reached the articular surface. Follow up on 04/16/14 provided no physical examination. Surgery was recommended.

The requested right knee arthroscopy with lateral meniscectomy was denied by utilization review on 05/02/14 as there was no evidence of an appropriate course of conservative treatment. Physical examination findings were also non-specific for a meniscal tear.

The request was again denied by utilization review on 05/09/14 as there were no clear objective findings regarding meniscal tearing and there was no conservative treatment documented.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The patient presents with complaints of right knee pain with associated weakness and swelling. Physical examination findings did note effusion within the right knee as well as pain at 30 degrees flexion with varus and valgus stress testing. McMurray's signs as well as Apley's signs were noted to be negative on physical examination. There is no indication of any joint line tenderness laterally at the right knee. MRI studies did note a horizontal meniscal tear in the lateral meniscus; however, there was no indication that this was a tear extending to the articular surface. The patient's physical examination findings were not indicative of a symptomatic meniscal tear. There was no locking or catching described in the clinical reports. There was also insufficient documentation regarding conservative treatment. Guidelines do recommend that patients be refractory to a reasonable course of conservative treatment which includes medications, physical therapy, and activity modifications. As the clinical documentation submitted for review does not meet guideline recommendations regarding the requested procedures, it is this reviewer's opinion that medical necessity is not established at this time and the prior denials are upheld.

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)