

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/05/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left knee arthroscopy, removal of intra articular cyst

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 this reviewer that the request for a left knee arthroscopy, removal of intra articular cyst is recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his left knee following sudden onset of pain after hyperextension injury. Clinical note dated indicated the patient complaining of discomfort at the left knee which was restricting his activities including walking running and exercising. The patient reported swelling and general instability at the left knee. Pain was exacerbated with stair climbing as well as walking. Upon exam the patient demonstrated 0-120 degrees of range of motion at the left knee. Strength was decreased. The patient was identified as having positive patellar grind test with positive McMurray at the medial joint line. The patient was provided with a sleeve for the knee and was recommended for MRI. MRI of the left knee dated 01/31/14 revealed 18mm lobulated cystic mass at the posterior medial intercondylar notch. This also raised the possibility of an occult medial meniscal tear. All other ligaments were intact. Healed fibrous cortical defect abutting the posterior cortex of the upper one half of the tibia was measuring 5.5cm was also revealed. The clinical note dated 02/03/14 indicated the patient continuing to complain of moderate pain described as an aching quality. The patient was treated with nonsteroidal medications and rest, activity modification, and non-narcotic pain medications. The patient responded well to medications. The patient continued with range of motion and strength deficits at the knee. The utilization reviews dated 02/21/14 and 03/26/14 resulted in denials as no information was presented regarding previous involvement with physical therapy or injections.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Clinical documentation indicates the patient complaining of left knee pain after hyperextension injury. MRI revealed 18mm lobulated cystic mass filling the posterior medial condylar notch. The patient was also

identified as having a healed fibrous cortical defect measuring 5.5cm. Given the findings confirmed by imaging studies and taking into account the ongoing functional deficits manifested by the range of motion deficits measured to be 0-120 degrees this request is reasonable. As such, it is the opinion of this reviewer that the request for a left knee arthroscopy, removal of intra articular cyst 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)