

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Feb/11/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left knee arthroscopy partial medial menisectomy chondroplasty synovectomy and Cardiac Clearance

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

Board Certified General 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Physical therapy reports 11/13/13-11/29/13

Physical therapy for patient 12/09/13 and 12/11/13

MRI left knee 11/02/13

Clinical record 11/07/13

Clinical record 11/12/13

Clinical record 12/03/13

Clinical record 12/10/13

Clinical record 12/18/13

Clinical record 12/18/13

Clinical record 01/15/14

Peer review report 12/31/13

Utilization review reports 12/27/13 and 01/10/14

Carrier submission report 01/31/14

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx when he fell twisting his left foot and knee. The patient attended physical therapy through November of 2013 for the left knee. The patient had a prior history of heart disease and was utilizing medications including Plavix and Lipitor. MRI of the left knee on 11/02/13 demonstrated oblique tear within the posterior horn of the medial meniscus contacting the tibial surface. No lateral meniscal tears were

identified. There was moderate chondromalacia in the central trochlear groove inferiorly with articular cartilage fissuring in the median ridge of the patella. There was a moderate amount of joint effusion with a large dissecting popliteal cyst extending superiorly from the joint measuring approximately 6.5cm. The patient was seen on 12/18/13 for continuing complaints of left knee pain at the medial joint line. The patient demonstrated antalgic gait. Physical examination demonstrated markedly positive medial McMurray and Apley signs. Due to the failure of physical therapy the patient was recommended for left knee arthroscopy including meniscectomy and chondroplasty. Follow up on 01/15/14 again reported positive McMurray and Apley signs in the left knee with medial joint line tenderness. There was 1-2+ effusion within the left knee. The requested surgical procedures were non-certified by utilization review on 12/27/13 as there was no indication that physical therapy or activity modifications had been performed. The request was again non-certified by utilization review on 01/10/14 as there was no documentation regarding non-operative treatment.

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

The patient has been followed for ongoing complaints of left knee pain following a twist and fall injury. The clinical documentation included multiple physical therapy reports through 11/13. Physical examination findings clearly demonstrated evidence of asymptomatic medial joint a symptomatic medial meniscal tear as there were markedly positive Apley and McMurray signs. The patient also demonstrated medial joint line tenderness. MRI identified a posterior medial meniscal tear extenuating to this extending to the surface which is consistent with exam findings. Given the documentation regarding failure of non-operative treatment including physical therapy and clear positive findings for asymptomatic meniscal tear the requested surgical procedures would meet guideline recommendations. Given the noted prior heart disease including multiple cardiac procedures a pre-operative cardiac clearance would be medically necessary and appropriate for this patient. As such it is the opinion of this reviewer that medical necessity for the proposed procedures and cardiac clearance is established the prior denials are overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES