

DATE: 08/20/14

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 08/20/14

IRO CASE #:

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

M.D., Board Certified in Orthopedic Surgery

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right knee arthroscopy with medial and lateral meniscectomies (CPT codes 29877 and 29876)

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)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
712.1	29877		Prosp.				Xx/xx/xx		Overturned
712.1	29876		Prosp.				Xx/xx/xx		Overturned

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant is a male with a previous anterior cruciate ligament reconstruction who slipped and fell on xx/xx/xx and twisted his right knee. He developed immediate pain, swelling, and limited range of motion. He was seen, evaluated, and treated and was felt to have medial and lateral meniscal tears. MRI scan demonstrated partial tearing of his ACL reconstruction and medial and lateral meniscal tears, as well as microtrabecular bone contusions and bone fractures. Surgery was recommended, but denied after a Peer Review. The Peer Review recommended rehab. The claimant was sent for rehabilitation, but continued to have symptomatology, and once again surgery was requested, but denied multiple times by the insurance company. It has been sent for independent review. The claimant continues to have limited range of motion, positive McMurray's sign, and pain in his knee.

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

I disagree with the insurance company denial. The claimant has an acute injury to the knee and has suffered MRI scan documented medial and lateral meniscal tears, as well as potential injury to his previous ACL reconstruction. He has failed conservative management and is an absolute candidate for a knee arthroscopy with indicated procedures, such as medial and lateral meniscectomy and other procedures depending on the status of his ACL reconstruction or articular cartilage, which would be an intraoperative decision. This decision is based on the Official Disability Guidelines and clinical practice.

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

- ACOEM-American 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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)