

True Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

True Resolutions Inc.
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Case Number:

Date of Notice: 07/09/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Right DKA with lateral release, possible CP or dCP, possible synovectomy, possible TAI.
If the surgery is approved, the review of 7 day rental cryotherapy unit

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)

Patient Clinical History (Summary)

is a female with complaints of knee pain. On xx/xx/xx, the patient was seen. She stated she injured her right knee 5 days prior to the exam and was told in the emergency room that she fractured her patella and was wearing a brace. Physical examination was deferred due to pain. On 03/05/15, an MRI of the knee was obtained documenting grade 2 chondromalacia of the patella. There was more diffused thinning of the cartilage in the lateral and medial compartments without subchondral edema in any of those locations. A small joint effusion was noted. This was compared to previous x-rays showing a subtle vertical lucency projecting over the upper pole of the right patella stated to be artifact or subtle fracture. On 06/23/15, the patient returned to clinic. She complained of right knee pain and stated she landed on something sharp while squatting on a mat at work. She stated the previous physical therapy had helped a little bit and a previous injection had helped temporarily. On exam she had 1+ effusion and had lateral maltracking with loss of the normal J-curve to the right knee. She was tender about the lateral trochlear groove and lateral patellar facet. She had decreased strength in flexion rated at 3/5 and decreased strength in extension rated at 4/5. Pain was elicited by motion.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 05/15/15, a utilization review report was submitted for the requested procedure noting it had not been authorized. This was based on the 05/14/15 report noting that there was no evidence that the patient had patellar instability or had an original incident in which there was a patella dislocation and there was no evidence as to how many PT visits had been performed or what the main concentration of therapy was. The provided imaging did not indicate either lateral tracking or pathology of the medial retinaculum but rather showed a defect medially than laterally. Therefore the proposed procedure was not likely to relieve the patient's symptoms and the request was non-certified. Therefore the requested 7 day rental of a cryotherapy was also not considered medically necessary. On 06/10/15, a non-certification request on appeal was submitted for the requested procedure supported by a 06/05/15 report in which it was noted that there was a lack of abnormal patella tilt and there was no report by an independent orthopedic surgeon recommending arthroscopy and lateral release and associated procedures. Therefore the request was not supported as being medically necessary. As such, the requested cryotherapy would also not be supported. The records provided for this review include the MRI of the right knee dated 03/05/15 which demonstrates that the patellar retinaculum is intact. There is grade 2 chondromalacia of the patella and the patient does report knee pain

which may be the pain generator for this patient. There is no evidence of patella maltracking on that exam. Guidelines recommend a lateral release after documented physical therapy, with subjective complaints of pain, and a normal patella tilt on x-ray or CT or MRI has been documented. Therefore, it is the opinion of this reviewer that the request for a right DKA with lateral release, possible CP or DCP, possible synovectomy, possible TAI is not supported and the request for 7 day rental cryotherapy is not supported 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 and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and 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-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)