

# C-IRO Inc.

An Independent Review Organization

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**DATE NOTICE SENT TO ALL PARTIES:** May/08/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** left knee arthroscopy

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic 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.** It is the opinion of this reviewer that the request for a left knee arthroscopy is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his left knee on xx/xx/xx when she slipped on an air hose resulting in a popping sensation in the knee. The MRI of the left knee dated 10/10/14 revealed a non-displaced tear of the medial meniscus posterior horn involving the central portion. Degenerative changes were also identified at the medial meniscus as well. A mild MCL strain with a mild medial patellar retinacular strain was further revealed. Tendinosis was identified at the quadriceps. Moderate joint effusion was further revealed. The clinical note dated 02/13/15 indicates the patient utilizing Ibuprofen for ongoing pain relief. There is an indication the patient was undergoing physical therapy at that time. Upon exam, tenderness was identified upon palpation over the medial joint line along with mild effusion.

The utilization review dated 03/10/15 resulted in non-certification as insufficient information had been submitted regarding the patient's functional deficits as well as a completion of all conservative treatments.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient complaining of left knee pain. An arthroscopic procedure would be indicated at the knee provided the patient meets specific criteria to include completion of all conservative treatments and the clinical exam confirms the patient's functional deficits. There is an indication the patient had initiated physical therapy. However, no information was submitted regarding the patient's completion of any other additional conservative treatments. Additionally, no therapy notes were submitted for review. Furthermore, there is inadequate information regarding the patient's functional deficits as there appears to be tenderness at the medial joint line. However, no range of motion, strength, or endurance deficits were identified in the clinical notes. Given the lack of information regarding the patient's clinical presentation as well as information regarding the completion of all conservative treatments, this request is not fully indicated. As such, it is the opinion of this reviewer that the request for a left knee arthroscopy is not recommended as medically necessary 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)**