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DATE NOTICE SENT TO ALL PARTIES: Feb/15/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: OP; Left knee scope w/medial meniscectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 <u>each</u> health care service in dispute. It is this reviewer's opinion that medical necessity for OP; Left knee scope w/medial meniscectomy has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX after falling down stairs injuring his neck, left shoulder, back, head, and left knee. The clinical records began in XX/XXXX when the patient was seen for constant and severe left shoulder pain and instability in the left knee. The patient attended two different periods of physical therapy, one in XX/XXXX and a later period through XX/XXXXX. It is unclear what if any recent medication use was prescribed to the patient. There was an MRI study of the left knee from XX/XX/XX noting a small to moderate sized oblique type tear of the posterior horn of the medial meniscus extending to the inferior articular margin with some blunting of the free edge. The patient was seen on XX/XX/XX for ongoing complaints of left knee pain. The patient described limit limited range of motion the left knee as well as the left shoulder. The patient's physical examination noted no evidence of instability in the left knee left knee with some loss of range of motion. There was tenderness anteriorly in the left knee. No specific meniscal findings were identified. Prior to this evaluation the XX/XX/XX clinical record from XX noted medial sided tenderness at the left knee with no evidence for instability. The requested left knee arthroscopy for medial meniscectomy was denied by utilization review on XX/XX/XX as there was limited documentation regarding meniscal type symptoms such as locking clicking or popping as well as physical examination findings such as a positive McMurray sign, effusion, or limited range of motion. There was also no documentation regarding recent physical therapy. The request was again denied on XX/XX/XX due to lack of physical examination findings as well as documentation regarding physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for both left shoulder and knee pain and has been recommended for surgical intervention. The additional records provided for review noted continuing physical therapy through XX/XXXX. Currently it is unclear how the patient ultimately responded to physical therapy as the last clinical evaluations for the patient were completed in XX/XX/XX. There is no more recent evaluation of this patient. The evaluations provided equivocal findings for a symptomatic meniscal tear. There were no clear findings for a positive McMurray sign or medial joint line

tenderness. XX found tenderness only anteriorly in the left knee. There were no subjective symptoms of a meniscal tear such as locking, popping or clicking. Overall the clinical records did not meet Official Disability Guidelines recommendations regarding meniscectomy procedures, especially for younger patients. Therefore, it is this reviewer's opinion that medical necessity for OP; Left knee scope w/medial meniscectomy has not been established and the prior denials remain 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

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

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)