Core 400 LLC

An Independent Review Organization
3801 N Capital of TX Hwy Ste E-240 PMB 139
Austin, TX 78746-1482
Phone: (512) 772-2865
Fax: (530) 687-8368
Email: manager@core400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/16/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: OP 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:

[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 the opinion of this reviewer that medical necessity for the requested OP left knee arthroscopy in this case has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who sustained an injury on xx/xx/xx when she slipped and fell injuring her left knee. Patient described popping in the medial side of the left knee with pain on range of motion. The patient was provided anti-inflammatories and analgesics for pain and was referred for physical therapy. The patient attended physical therapy from October to December of 2014. Radiographs of the left knee from 08/19/14 were normal. MRI of the left knee dated 08/19/14 noted mild amount of joint effusion with no evidence of fracture dislocation. There was no evidence of internal derangement. There was grade 2-3 chondromalacia at the patella evident. CT of the left knee on 01/09/15 noted no specific findings. The patient was followed for continuing complaints of left knee pain. As of 01/16/15 the patient continued to have some relief with muscle relaxers and anti-inflammatories. The patient described some mild feelings of giving way in the left knee without walking. Physical examination at this visit noted tenderness over lateral patellar facet pure. The hew angle was less than 15 degrees and there was full range of motion with some pain at the extremes. There was no instability evident. The patient was recommended for a diagnostic arthroscopy. The request was denied by utilization review on 12/18/14 as the submitted CPT codes included lateral retinacular release and shaving of articular cartilage. Although CPT code 29877 was recommended the decision was for non-certification due to lack of peer to peer consultation. The request was again denied on 01/28/15 as no additional records were available for review showing abnormal patellar tilt to support the submitted requests for chondroplasty and lateral retinacular release.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient was followed for persistent complaints of left knee pain that continued despite physical therapy and medications. Physical examination findings are relatively unremarkable. There is pain with extremes there is pain at the extreme end of range of motion in the left knee without evidence of locking. Some joint line tenderness was evident however there was no evidence of substantial

effusion loss of range of motion or any palpable clicking or locking. The patient denied locking symptoms. Imaging studies noted patellar chondromalacia grade 2-3 in severity; however, there was no distinct chondral chondral flaps or injuries to support surgical intervention. Although the clinical records recommended a diagnostic arthroscopy the submitted requests were for chondroplasty and lat rat lateral retinacular release. As previously noted there was no evidence of an abnormal cue angle in the left knee to support surgical intervention to allow retinacular release. Given the further MRI given the negative MRI findings for any chondral injury or flap tears chondroplasty as well would not be supported as medically appropriate. Therefore, is it the opinion of this reviewer that medical necessity for the requested OP left knee arthroscopy in this case has not been established and 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

[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)