IMED, INC.

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX knee scope XX

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

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX while doing XXXX. The records noted a previous knee injury in XXXX for which the claimant received therapy but required an anterior cruciate ligament reconstruction. The claimant described XX knee swelling after the most recent injury at the medial aspect. The claimant was initially prescribed XX and did attend formal physical therapy through XXXX without substantial improvement. The XXXX XX knee MRI noted a XX XX without a clear tear. Prior surgery was suspected vs. degeneration. No XX XX tearing was reported. The XXXX clinical report noted continuing XX knee pain with catching and feelings of instability. The physical exam noted medial joint line tenderness at the XX knee but negative XX. There was a positive XX sign reported. No instability was evident.

The requested XX knee meniscectomy was denied by utilization review; however, prior opinions for the denial were not provided for review.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The claimant presented with a prior history of a XX knee anterior XX injury in XXXX that was repaired. The claimant had no issues until the XXXX date of injury and reported XX knee pain with catching and feelings of instability. The claimant had not improved with medications or

physical therapy. The recent physical exam did note medial joint line tenderness at the XX knee with a positive XX sign. However, MRI studies failed to demonstrate clear evidence of a XX tear that would correlate with the partial physical exam findings for a symptomatic XX tear. Given these issues which do not meet guideline recommendations, it is this reviewer's opinion that medical necessity is not established, and the prior denials are upheld.

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

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**