



Notice of Independent Review Decision

DATE OF REVIEW: 12/19/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of the previously denied request for a left knee arthrogram/MRI.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas licensed Chiropractor.

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)

The previously denied request for a left knee arthrogram/MRI.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice to Inc. of Case Assignment dated 12/11/07.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 12/10/07.
- Company Request for Independent Review Organization dated 12/6/07.
- Request for a Review by an Independent Review Organization dated 12/5/07.
- Determination Notification Letter dated 11/28/07, 11/13/07.
- Treatment Recommendation Note/Authorization Request dated 10/16/07.
- Preliminary Diagnosis/Problems Knee/Elbow dated 10/16/07.

- xxxxxxxs dated 10/16/07.
- Treatment Plan dated 10/16/07.
- Examination Notes/Comments dated 10/16/07.
- Evaluation Note dated 10/5/07.
- SOAP Note dated 10/3/07.
- Medical Necessity Letter dated 11/14/07.
- Causation/Treatment Plan Letter dated 9/27/07.
- Physical Performance Examination (#2) Report dated 8/7/07.
- Knee MRI (without Contrast Enhancement) dated 6/13/07.

No guidelines were provided for this referral.

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xx years

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: xxxxxx.

Diagnosis: xxxxxx

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The patient is a xx-year-old male who had complaints of xxxxxxxx. Medical records provided consisted of several reviews, an MRI of the left knee, an orthopedic evaluation, a whole person functional capacity evaluation (FCE) and therapy notes. The patient has had 12+ treatments of physical therapy and active care for his injuries. He has had an MRI of the knee which had findings of a small amount of joint effusion, mild patello-femoral arthrosis with posterior patellar cortical bone thickening, no osteochondral defect, no popliteal or inner degenerative signal. Medial and lateral menisci well visualized and intact, without thickening or tearing. The only increased signal was posterior to the patella, all as read by Dr, , MD. In the Official Disability Guidelines set out that, "All patients with meniscal resection of more than 25%, who do not have severe degenerative arthrosis, chondral injuries, or avascular necrosis required MR arthrography." Patients with less than 25% meniscal resection do not need MR arthrography. Since the patient had no meniscal injury the request for an MR arthrogram is denied.

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

- ACOEM – AMERICAN 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.
717.0 Old Bucket Handle Tear of Medial Meniscus.
- 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee’s employer, the injured employee’s insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.
