IRO America Inc.

DATE OF REVIEW:
MARCH 21, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Repeat right knee MRI

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

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Work status notes, 01/18/06, 01/23/06, 02/03/06, 03/17/06, 04/12/06, 04/29/06, 06/01/06, 06/29/06, 09/20/06, 10/06/06, 11/29/06, 01/02/07 and 01/24/07
Office notes, Dr., 01/18/06, 03/17/06, 04/12/06, 04/29/06, 06/01/06, 08/07/06, 09/20/06, 10/06/06, 11/29/06, 01/02/07 and 01/24/07
Laboratory studies, 06/13/06
Office Notes, 01/11/06, 06/29/06, 02/03/06
Therapy notes, 06/30/06 to 07/19/06
MRI right knee, 01/25/06
X-ray right knee, 11/01/06
Operative report, 06/15/06
Office notes, Dr., 02/28/06, 03/30/06, 08/10/06, 09/07/06, 09/21/06 and10/21/06
Office notes, Dr., 10/16/06 and 10/25/06
Office note, Dr., 12/07/06
Note, 01/12/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient is a assistant principle injured on when a chair was pushed into his right knee. He had a history of a previous right knee meniscectomy, but records suggest he had been asymptomatic.

He was treated conservatively by Dr. with work restrictions and medications. The MRI of the right knee showed a medial meniscus which was suggestive of recurrent tear and mild medial osteoarthritic changes. The Patient came under the care of Dr. 02/28/06. On examination there was full motion. On the following visit of 03/30/06 there was a positive McMurray. Therapy and activity modification were recommended.

On 06/15/06 the Patient was taken to the operating room for arthroscopy with chondroplasty of the medial femoral condyle. No recurrent medial meniscal tear was noted. Following surgery the Patient regained motion, but continued to have mild residual pain and on 08/21/06 Dr. recommended an osteochondral graft. Surgery was denied. McMurray maneuver still caused medial pain on the 09/21/06 examination with no clicking or locking. He was to modify his activities and to perform exercises.

On 12/07/06 Dr. evaluated the Patient for progressive pain. On examination motion was 0-135 degrees with a mildly positive McMurray. There was also patellofemoral crepitus. X-rays showed medial thinning without osteophyte formation. Dr. assessment was an osteochondral lesion and partial meniscectomy. He recommended an MRI to determine if the lesion had increased in size. If so, he opined that the treatment outlined by Dr. should be considered. The MRI was not certified and the decision has been appealed.

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

The Patient had a microfracture procedure to the knee in 06/06, but has had ongoing pain with some catching. A new MRI has been recommended to assess the size of the lesion. The MRI would not be considered as medically necessary. There is no indication that the Patient is a candidate for osteochondral surgery as proposed by Dr. as the Patient exceeds the recommended age and there is no indication of the size of the lesion that would be addressed. There has been no sudden change in the condition or examination findings. As such, the MRI would add little in the way of information and would not at this point alter the plan of treatment.

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
- ☐ 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)