

**Notice of Independent Review Decision**

**Date of Review:** 06-09-08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

MRI of right knee and plain film right knee

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

Certified by The American Board of Orthopaedic Surgery

**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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	717.8 728.85 728.9		Upheld

**Notice of Independent Review Decision**  
**Page 2**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Notice of Utilization Review Findings dated, 04-28-08, 05-13-08  
Letter of Medical Dispute Resolution dated, 01-30-07  
Electrodiagnostic Results dated, 04-07-08, 10-15-07  
MRI right knee dated, 03-07-07, 02-16-07,  
Knee Right 3 views dated, 01-30-07  
MR- Pelvis dated 11-14-07  
Status Report Cervical/Lumbar dated, 03-07-08  
Physical therapy daily notes dated, 11-13-07 to 11-28-07, 12-13-07 to  
12-17-07, 01-14-08 to 01-28-08, 03-07-08, 04-03-08 to 04-30-08  
Physical Capacity Report, dated, 01-30-07  
Physician medical notes dated, 01-30-07, 02-07-07, 02-13-07, 03-26-07,  
05-30-07, 04-09-07, 04-17-07, 08-29-07, 01-03-08, 05-08-08  
Medical Evaluation Reports dated, 01-07-08, 05-20-08, 06-28-07  
Letter of Clarification dated, 09-10-07, 12-06-07, 05-22-08  
Consultation reports dated, 01-30-07, 05-21-07  
Procedure notes dated, 05-22-07, 01-10-08  
Daily Patient Record dated, 02-22-07 to 02-28-07, 03-02-07 to 03-22-07,  
07-11-07 to 07-27-07  
Initial Medical Narrative Report and subsequent notes dated, 08-01-07 to  
08-30-07, 09-04-07 to 09-28-07, 10-01-07 to 10-30-07, 11-01-07 to  
Letter of Reconsideration dated, 05-05-08  
Notice of Disputed Issues and Refusal to Pay Benefits dated, 03-05-07,  
08-10-07, 08-08-07, 08-23-07, 09-18-07, 10-15-07, 10-24-07, 12-19-07  
Official Disability Duration Guidelines (ODG) –Treatment in Workers'  
Compensation 2008 web-based edition

**PATIENT CLINICAL HISTORY:**

This claimant was injured on a fall while at work. Subsequently underwent right knee surgery. Included in the records submitted are physical therapy progress notes indicating that therapy was continuing. The progress note of April 23, 2007 documented that the March 2007 MRI noted bone marrow lesion, posterior medial femoral condyle cartilage irregularity and a medial meniscus tear. Electrodiagnostic studies note sciatic nerve changes.

The March 31, 2008 progress note indicates that there is a CRPS Type II, a chronic pain syndrome and right knee pain. A specialty consultation was sought

**Notice of Independent Review Decision**  
**Page 3**

and a repeat MRI was apparently needed for consultation. Additional physical therapy was provided.

The request for a repeat right knee MRI was non-certified. There was a reconsideration appeal and this was non-certified. It was noted that the claimant was to be seen in consultation by specialist and current films are a requirement.

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

In the opinion of the Reviewer, review of the ODG relative to knee MRI, and based on medical documentation, there is no clear clinical indication for the medical necessity for a repeat MRI of the right knee including plain films for this claimant.

According to the records, the claimant sustained a knee injury and was surgically treated with arthroscopy. The findings at arthroscopy were not noted. There is diagnosis of chronic knee pain and chronic regional pain syndrome type II.

In the May 19, 2008 letter of medical dispute, there is notation of knee instability, however, that findings is not noted on any of the previous progress notes by the treating provider.

**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

**Notice of Independent Review Decision**  
**Page 4**

- 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)**