

Applied Resolutions LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: October 16, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for outpatient repeat MRI right knee

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Office notes, Dr. , 03/05/08, 03/10/08, 04/23/08, 05/14/08, 09/15/08
MRI right knee, 03/6/08
Office note, , PA-C, 03/24/08
DDE, Dr. I, 05/23/08
Denial Letters 09/18/08, 09/30/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old female with right knee pain after a twisting incident on xx/xx/xx. The MRI of the right knee of 03/06/08 showed moderate severe degenerative changes of the medial joint compartment characterized by signal abnormality of the posterior horn, peripheral migration of the anterior body and anterior horn and moderate severe medial joint space chondromalacia. Edema overlying the medial retinacular ligament that was non specific but mimics a retinacular tear was reported. A tiny coronally oriented

tear of the anterior horn of the lateral meniscus that was peripheral involving the superior articular surface was reported. Dr. saw the claimant on 09/15/08. The claimant reported progress with light duty and bracing until she re-twisted her knee at work. Examination revealed right knee tenderness to the medial joint line and good range of motion with pain at the extremes of extension and flexion. X-rays of the right knee that day showed no acute bony changes and some decreased joint space which was unchanged from previous films. Dr. noted that the claimant was doing fairly well until the reinjury at work.

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

This claimant did undergo an MRI in March of 2008. Although there has been a reported "twist" on the work site, there are really no additional physical findings to suggest a new injury.

The medical records alone do not support the authorization of a new MRI in this case. This case would not fit the ODG guidelines.

Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, knee

Indications for imaging -- MRI (magnetic resonance imaging):

- Acute trauma to the knee, significant trauma (e.g., motor vehicle accident), suspect posterior knee dislocation.
- Nontraumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed.
- Nontraumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary, and if internal derangement is suspected.
- Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected.
- Nontraumatic knee pain, adult - nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Peligrini Stieda disease, joint compartment widening).

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)