



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 08/24/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Knee Arthrogram w/ Post MRI Scan

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

Board Certified in Orthopedic 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)

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.

Left Knee Arthrogram w/ Post MRI Scan - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Employer's First Report of Injury or Illness, ,
- Doctor Visit, , 04/09/07, 05/01/07, 09/12/07, 09/10/08, 09/29/08, 11/06/08, 12/09/08, 01/15/09, 02/02/09, 02/19/09, 03/17/09
- Physical Therapy, , 04/09/07, 04/11/07, 11/13/07, 11/17/07, 11/27/07, 11/29/07, 11/30/07, 12/04/07, 12/07/07, 12/11/07, 12/14/07, 12/26/07, 12/28/07, 01/10/08, 01/11/08, 01/15/08, 01/16/08, 01/18/08, 01/23/08, 01/23/08, 01/29/08, 01/30/08, 02/05/08
- MRI of the Right Knee, M.D., 05/03/07
- Evaluation, , M.D., 10/04/07
- Right Knee Arthroscopy, , M.D., 10/30/07
- DWC Form – 73, Dr. , 11/06/07, 11/29/07, 01/24/08
- Certificate of Medical Necessity, Dr. , 12/10/07
- Clinic Note, Dr. , 12/27/07, 03/27/08, 05/22/08, 08/21/08
- Right Knee Arthrogram with Computed Tomography, M.D., 04/23/08
- Right Knee Arthrogram, , D.O., 04/23/08
- Health & Behavioral Assessment Interview & Testing, , Ed.D., 10/02/08
- Medical Progress Note, , M.D., 11/10/08, 12/19/08
- Designated Doctor Evaluation, M.D., 03/04/08, 06/26/08, 11/20/08
- MRI Left Knee, , M.D., 01/23/09
- Letter of Clarification, Dr. , 03/04/09
- Second Opinion Orthopedic Consultation, D.O., 03/13/09
- Independent Medical Evaluation, , M.D., 03/25/09
- Chiropractic Rehabilitation, , D.C., 05/18/09, 05/27/09, 06/03/09, 06/24/09
- Interdisciplinary Case Management Conference, , LPC, 06/15/09
- Physical Examination, Unknown Provider, 07/06/09
- DWC – Form – 73, Dr. 1, 07/14/09
- Denial Letter, , 07/15/09, 07/24/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient injured her knees and they began to swell and hurt. She was conservatively treated with physical therapy, MRI of both knees, arthrogram of the right knee, as well as treatment with a chiropractor.

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

A left knee arthrogram with post MRI scan is not medically reasonable or necessary. The patient has undergone a left knee MRI scan that was significant for indicating findings of a probable chronic small flap tear of the medial meniscus in the posterior medial corner with generalized capsulitis and grade 3 chondromalacia of the medial facet of the

patella and posterolateral compartment. That MRI scan was performed on 01/23/09. The radiologist at that time did not indicate the need for an arthrogram to clarify his findings, and ODG states that arthrography with MRI scan for the knee is routinely indicated for patients that are post partial meniscectomy when more than 25% of the meniscus has been removed. In this case, there is no prior surgery to the knee and no indication of intervening injury since the 01/23/09 MRI. Therefore, at this time I do not see information in the medical records that would support the need for an MRI scan of the left knee with contrast.

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)