



Specialty Independent Review Organization

DATE OF REVIEW: 2/22/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include an MRI of the right knee.

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

The reviewer is a Doctor of Chiropractic who has been practicing for approximately 15 years.

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 reviewer disagrees with the previous adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): : LMN of 2/4/09, progress notes from 11/25/08 to 1/20/09 by MD and 8/11/08 operative report.

LHL009, 12/9/08 denial letter, 12/12/08 denial letter, 12/5/08 peer review report, 12/4/08 LMN and 12/10/08 peer review report.

We did not receive a copy of the ODG from the carrier or URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This worker was injured in xx/xx during the course and scope of her employment. This injury consisted of being struck with a pallet jack which caused

her to fall to her knees. The records indicate that her company did not allow her to see a physician for two months post injury. An MRI was ordered by Dr. (this study is not included in any of the records from the carrier or TD) A surgical repair to the ACL was performed in August of 2008. The records indicate a post operative PT program was performed. However the exact number (records indicate approximately 12) and type of treatments was not determined. A repeat MRI is at question for this patient.

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

It is obvious to the reviewer that 12 post operative therapy sessions for an ACL reconstruction is not appropriate. However, the question is not the medical necessity of PT but the medical necessity of an MRI (repeat). Dr. indicates in his letter of medical necessity that a further 6 visits of PT have been provided with no change in the patient's symptomatology. This complies with the objections of the peer reviewers to the initial request for MRI. The ODG does not specifically indicate the indications for a repeat MRI; therefore, the indications for an MRI are below as per the ODG.

- 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).

At this point in treatment, this patient has not suffered any recently traumatic events according to the records. According to Dr., carrier reviewer, he references the "ODG treatment guidelines for the knee regarding MRI- ...this study concluded that, in patients with non-acute knee symptoms who are highly suspected clinically of having intra-articular knee abnormality, magnetic resonance imaging should be performed to exclude the need for arthroscopy."

This patient is definitely not acute and is suspected of having a clinical knee abnormality; therefore, the ODG guides indicate the procedure is medically necessary at this time.

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)