



Lumetra

Brighter insights. Better healthcare.

One Sansome Street, Suite 600
San Francisco, CA 94104-4448

415.677.2000 Phone
415.677.2195 Fax
www.lumetra.com

Notice of Independent Review Decision

DATE OF REVIEW: 10/1/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI right knee with and without contrast

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

Licensed by the Texas State Board of Chiropractic Examiners

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination 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		73722, 73721	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Letter to IRO dated 9/29/09

MRI report dated 1/16/09

Physicians' notes dated 2/9/09, 3/9/09, 3/10/09, 4/7/09, 4/15/09, 4/21/09, 5/19/09, 5/27/09, 8/25/09

FCE dated 6/3/09

Reference article: Special Studies and Diagnostic and Treatment Considerations

Official Disability Guidelines cited but not provided

Notice of Independent Review Decision
Page 2

PATIENT CLINICAL HISTORY:

This claimant sustained a right knee injury on xx/xx/xx when he stepped in a hole which caused his knee to twist outward with immediate pain and swelling. Treatment has included therapy, injection, medications, surgery (April 2009), and post op therapy. The claimant continues to have problems with his knee. A repeat MRI right knee with and without contrast was requested.

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

In the Reviewer's opinion, the requested service is not medically necessary for this claimant. Based on ODG, there was no significant trauma post-arthroscopic repair and no remarkable clinical/objective findings that supported a repeat MRI. The Reviewer noted that there was no clinical data that supported the claimant had an intra-articular lesion requiring the requested imaging. In addition, there was no indication in the records that AP and lateral radiographs had been obtained post arthroscopy. Based on ODG, American College of Radiology (ACR) Appropriateness Criteria, the requirement for MRI in this case is not appropriate. The initial MRI demonstrated the claimant only had a tear in the posterior horn of the medial meniscus that had progressed from a prior study in 2008. All ligaments and the lateral meniscus were intact. Post arthroscopy, there was no new trauma or significant clinical basis for a repeat MRI.

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 3

- 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)**