

C-IRO Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the right knee without contrast

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

Doctor of Medicine (M.D.), Board Certified in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Knee and leg chapter Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates

Adverse Determinations, 5/28/10 and 6/29/10

MD, 6/23/10, 5/12/10, 4/1/10, 2/18/10, 1/21/10, 1/7/10,

12/10/09, 9/30/09, 8/20/09, 8/5/09, 5/26/09, 4/29/09, 2/24/09, 2/23/09

Select Physical Therapy, August 2009-October 2009

Final Report, 1/18/10

MRI Right Knee, 2/23/09

PATIENT CLINICAL HISTORY SUMMARY

This is a woman injured approximately on xx/xx/xx. The patient continues to have severe knee pain despite medial and lateral meniscectomies one year ago. The patient does not have any mechanical symptoms. The patient did suffer a fall postoperatively.

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

The request for repeat MRI of the right knee without contrast is not medical necessary at this point in time. The patient has significant degenerative findings in the knee that would most likely explain the ongoing symptoms. There are no mechanical symptoms to warrant another MRI scan according to the records reviewed. There is no recent documentation of lower levels of care such as a steroid injection. The ODG guidelines are not satisfied. The reviewer finds that medical necessity does not exist for MRI of the right knee without contrast.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)