

SENT VIA EMAIL OR FAX ON
Nov/03/2010

Applied Resolutions LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/03/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Knee Arthrogram

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

AADEP Certified

Whole Person Certified

Certified Electrodiagnostic Practitioner

Member of the American of Clinical Neurophysiology

Chiropractor Physician

Clinical practice 10+ years in Chiropractic WC WH Therapy

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

Denial Letters 8/10/10 and 9/28/10

10/25/10

Dr. 6/1/06

OP Reports 1/10/07 and 6/30/08

MRI 3/9/07 and 9/17/09

Ortho 6/15/10

Chiro 6/9/10 thru 9/3/10

Peer Review 5/6/10

Orhtopaedics 1/12/10

Dr. 11/13/09 thru 4/21/10
Dr. 6/15/09 thru 6/29/09

PATIENT CLINICAL HISTORY SUMMARY

The injured worker was injured on xx/xx/xx. The injured employee injured when he was dumping contents from a wheelbarrow when it fell over and struck his right knee. The injured employee has undergone pharmaceutical medication management, physical therapy, braces/supports, canes and wheelchair, pain management, psychological therapy, two (2) separate surgical procedures, multiple advanced imaging procedures, multiple independent and required medication examinations, designated doctor examinations, and multiple specialist referrals. The injured employee was seen by Dr. on 6/15/2010 and he indicated that MRI did not reveal any abnormal findings other than a small bone bruise. Dr. impressions were internal derangement and requested to review additional medical documentation and made recommendations for postoperative MRI arthrogram.

Operative procedure of the right knee on 1/10/07 was for exploration of the biceps tendon, reattachment of the anterior arm of the biceps tendon, and exploration and decompression of the peroneal nerve at the right knee. MRI of the right knee on 3/2007 reported no indications of a tear in either meniscus. Operative procedure of the right knee on 6/30/2008 was for exploration of the right common peroneal and distal superficial and deep peroneal branches, neuro circumferential neurolysis, and resection of perineural neuroma. MRI of the right knee dated 9/17/2009 indicated that both meniscus were intact and there was some joint effusion.

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

The injured employee does not meet the ODG criteria for a MR arthrogram of the right knee. Medical records submitted did not objectively document evidence that supports MR arthrogram per ODG. All advanced imaging studies to date have not reported any meniscal abnormalities.

Both operative procedures did not involve the meniscus or a meniscal resection as indicated for MR arthrogram per ODG. Therefore, in view of the above the request for MR arthrogram is not indicated.

ODG Guidelines:

MR arthrography	Recommended for meniscal repair and meniscal resection of more than 25%. All patients with meniscal repair required MR arthrography. All patients with meniscal resection of more than 25%, who did not have severe degenerative arthrosis, chondral injuries, or avascular necrosis required MR arthrography. Patients with less than 25% meniscal resection did not need MR arthrography. (Magee, 2003)
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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)