

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Knee MRI without contrast

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

M.D., Board Certified Orthopedic Surgeon

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

Official Disability Guidelines

Dr. OV 09/28/10 , 10/19/10, 11/16/10 , 11/30/10, 12/16/10

MRI left knee 08/17/10

Functional Capacity Evaluation 09/08/10,

Physical Performance Evaluation 12/03/10

Dr. / progress notes 08/07/10, 09/27/10, 11/01/10, 11/29/10, 12/02/10, 12/29/10 01/03/11

Utilization Adverse Determination Letter 11/08/10, 12/13/10

Dr. / Medical Record Review 09/02/10

MD Rx 09/07/10

Problem Focused History./ Physical 09/07/10

PATIENT CLINICAL HISTORY SUMMARY

This is a female claimant who reportedly sustained a slip and fall on xx/xx/xx which resulted in a left knee injury. The diagnosis was of a lateral tibial plateau fracture left knee and meniscal tear left knee. A physician record dated 09/28/10 noted the claimant with left knee pain since the injury in xx/xx. Increased weight bearing as tolerated was recommended along with continuation of physical therapy. The claimant was unable to return to work.

A 10/19/10 physician record revealed the claimant with left knee pain over the proximal tibia both medially and laterally with continued moderate effusion despite conservative care which included medications, therapy, and off work. A repeat left knee MRI was recommended to evaluate for evidence of depression of the lateral tibial plateau. A follow up physician visit dated 11/30/10 noted continued left knee medial pain and pain with motion along with

continued swelling in the knee joint. Review of a CT scan performed on an unknown date showed arthritic changes in the medial compartment, medial tibial plateau fracture appeared healed and a downward slope of the posterior aspect to tibia plateau medially secondary to mild depression from the fracture. A repeat MRI of the left knee was recommended due to continued symptomatology to rule out a meniscal tear and other pathology.

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

Request is for left knee MRI without contrast. This is a female who sustained an injury xx/xx/xx. Diagnosis was that of a lateral tibial plateau fracture with medial meniscal tear. Physician note dated October 19, 2010 noted that there was left knee pain over the proximal tibia with an associated effusion. The patient had failed conservative treatment. A repeat MRI of the left knee was recommended. An MRI had been obtained August 17, 2010. This showed a non-displaced fracture of the lateral tibial plateau with bone marrow edema, moderate effusion with intact menisci. The patient also had a CT scan, the results of which were not reported. The physician note of Dr. November 30, 2010 states that there are arthritic changes. The rationale for repeat MRI is not adequately expressed. There was felt to be continued pain, but MRI showed no evidence of a meniscal tear.

The patient does not meet the criteria for repeat MRI. The patient has had continued complaints of pain. The patient has had rather an extensive diagnostic workup including an MRI, CT scan and plain films. The patient has not undergone any subsequent surgical procedure. A Left Knee MRI without contrast does not appear to be medically necessary at this time.

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)