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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Knee Cortisone Injection

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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with status post distal third tib/fib fracture of the left knee treated with intramedullary (IM) rodding in xxxx. His leg got caught in a truck door that was closing. The rod was removed at some point after the fracture had healed. The claimant has complained of left knee pain since then. MRI of the left knee on 08/21/09 showed a healed fracture of the proximal tibia with magnetic susceptibility artifact from previous surgical hardware, probable prior patellar tendon repair, and no internal derangement of the knee joint

The claimant was seen on 10/07/09 for left knee pain. It was noted at that visit that the claimant had one year of physical therapy and 15 knee injections. Range of motion was 10-65 degrees. The claimant had medial joint line tenderness and a positive McMurray. The physician recommended a diagnostic arthroscopy at that time but it does not appear that arthroscopy was done. X-ray of the left knee on 11/11/09 showed no evidence of acute bony abnormality. There was posttraumatic deformity of the left lower leg with healed tibial and fibular fractures.

Dr. performed a required medical evaluation on 06/28/10. The claimant was taking Norco 2-3 per day and Motrin three times a day. On exam left knee range of motion was 0-60 degrees. There was tenderness along the patella tendon, mild patellar sensitivity, and no effusion. Dr. noted that there was damage done to the patella tendon when the IM nail was removed. He recommended a cortisone injection of the knee and manipulation of the knee.

MRI of the left knee on 07/21/10 showed evidence of an old, healed fracture at the proximal tibia with removed hardware, question of previous partial medial meniscectomy, and mild patellofemoral and medial compartment osteoarthritis. X-ray of the left knee on 07/21/10 showed post surgical changes and minimal early osteoarthritic changes along the medial joint space compartment. Physical therapy was ordered on 09/20/10. At the 12/06/10 visit range of motion was 20-55 degrees. There was medial joint line tenderness. The physician recommended a cortisone injection which was denied on peer reviews dated 12/10/10 and 12/21/10 based on the claimant's history of multiple prior injections without knowledge of their benefit and the fact that guidelines recommend that the number of injections be limited to three.

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

The claimant has had chronic pain with limited motion. He has had 15 injections according to the records. The request is for an additional knee injection. Based on review of the records alone, the reviewer finds no medical necessity for Left Knee Cortisone Injection. The claimant has had a number of injections without a known response to such. It is unknown when the most recent injection was performed. It is unknown if he has had any recent surgery. The claimant has had multiple steroid injections, which did not provide relief. Therefore, at the present time the reviewer finds no medical necessity for Left Knee Cortisone Injection.

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)