

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/12/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the left knee

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

M.D., Board Certified Orthopedic 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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is employed. On xx/xx/xx she slipped landing on her knee. She is noted to have history of surgery in 11/20/10. Radiographs performed on 03/28/11 indicate medial joint space narrowing with spurring noted medially. No fractures were identified. On 04/22/11 the claimant was referred for MRI of left knee. This study notes a moderate joint effusion. The ligamentous structures are intact. The articular cartilage is narrowed particularly along the medial aspect of joint. There is grade II signal in the medial and lateral menisci without evidence of meniscal tear identified. There is some thickening of the medial collateral ligament with some intermediate signal noted. Spurring is noted on the patella. There is narrowing of the articular cartilage involving patellofemoral joint. There is focal area of increased signal noted in proximal tibia near the intracondylar eminence.

On 04/27/11 she was seen by, Dr. She presented with left knee complaints. She reports pain over the medial aspect of knee. She is 63 inches tall and weighs 216 lbs. Her past medical history includes left knee surgery. She is noted to have tenderness to palpation over the patella and patella tendon. She has medial joint line tenderness. No new meniscal pathology is noted. There is bone bruise noted over the proximal tibia. She subsequently underwent a corticosteroid injection and was recommended to receive Supartz injections.

When seen in follow-up on 05/12/11 the steroid injections were reported to have helped for 3 days. Dr. believes primary pain is from chondromalacia. She underwent a course of Supartz injections. On 05/26/11 she was seen by, Dr. regarding left foot pain. Dr. recommended that she undergo a triple arthrodesis with a gastrocssoleus recession.

On 07/13/11 she was seen in follow-up by, Dr. She is noted to be status post Supartz injections with the last being provided on 06/09/11. She has medial joint line tenderness. She is reported to have mild McMurray's. She is opined to have recurrent left knee pain. MRI of the left knee was recommended and denied.

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

This xx-year-old female sustained a slip and fall, which resulted in contusion of her left knee. She has past history of arthroscopic surgery left knee and has evidence of medial compartment osteoarthritis. There is no indication from initial imaging study that the claimant sustained a meniscal tear. She received conservative treatment, which included physical therapy, corticosteroid injections and viscosupplementation. She has had no substantive change in her physical examination to suggest presence of significant pathology. Based on the ODG guidelines for repeat MRI along with the information provided, the reviewer finds that there is no medical necessity for MRI of the left knee.

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)