

True Decisions Inc.

An Independent Review Organization
2002 Guadalupe St, Ste A PMB 315
Austin, TX 78705
Phone: (512) 879-6332
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

July/5/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI left knee

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

Board Certified Orthopedic Surgeon (Joint)

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes dated 03/01/13 – 06/17/13
Previous utilization reviews dated 05/24/13 & 06/07/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his left knee. The clinical note dated 03/01/13 details the patient having injured his left knee. The patient was noted to have returned to work where he slipped and reinjured the knee. The note does detail the patient having previously undergone a MRI. Upon exam, the patient was noted to have good alignment with no instability. A MRI revealed a small lateral meniscal tear according to the clinical note. The clinical note dated 05/17/13 details the patient continuing with left knee pain. Upon exam, mild lateral joint line tenderness was noted.

The previous utilization review dated 05/24/13 for a MRI of the left knee resulted in a denial secondary to a lack of significant changes involving the patient's left knee.

The utilization review dated 06/07/13 for a MRI of the left knee resulted in a denial secondary to no significant changes involving the patient's left knee.

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

The documentation submitted for review elaborates the patient complaining of left knee pain.

The documentation further details the patient having previously undergone a MRI of the left knee which revealed a meniscal tear. The Official Disability Guidelines recommend a repeat MRI of the knee provided the patient meets specific criteria to include significant changes involving either the pathology or symptomology. No information was submitted regarding the patient's significant changes involving the pathology or symptomology. Given that no information was submitted regarding the patient's significant changes involving the pathology or symptomology, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that the request for a MRI of the left knee is not recommended as medically necessary.

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)