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Notice of Independent Review Decision

Date notice sent to all parties: 06/24/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI of the left knee

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

Board Certified in 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)

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

Repeat MRI of the left knee - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Peer Review dated 05/16/13, which included curriculum vitae
Report dated 05/24/13
Radiology scheduling form dated 05/24/13
Utilization Review Referral dated 05/24/13
Notices of adverse determination dated 05/29/13 and 06/05/13

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 05/13/13, performed a peer review. The patient was injured on xx/xx/xx. The history was reviewed. felt ongoing medical treatment was not reasonable or necessary. He felt Motrin and Aleve as needed for pain was sufficient. On 05/24/13, examined the patient. She fell in the bathroom on xx/xx/xx and underwent left knee arthroscopy as well as a partial medial meniscectomy. She had had persistent pain and swelling in the knee since the surgery. She also felt her knee 'pops". She ambulated with a fairly normal gait and there was diffuse tenderness along the anteromedial, anterolateral, and straight anterior portion of the knee. There was no obvious effusion and she had full extension with flexion to 140 degrees. McMurray's was equivocal. X-rays revealed no fractures, bony lesion, or other significant bony abnormalities. The assessments were left knee medial mensicus tear and left patella tendinitis. Due to persistent pain, a repeat MRI was recommended. Celebrex and full duty were continued. On 05/24/13, provided a utilization review referral for the left knee MRI. On 05/29/13, provided an adverse determination for the request repeat left knee MRI. On 06/05/13, provided another adverse determination for the request MRI of the left knee.

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

When the patient was evaluated on 05/24/13, he documented no effusion and full extension with flexion to 140 degrees. X-rays were normal. McMurray's was equivocal and due to persistent pain, an MRI of the left knee was recommended. Per the ODG, repeat MRIs are indicated after surgery if there is a need to assess the knee cartilage repair tissue. However, the claimant does not have sufficient objective findings to warrant a repeat MRI per the recommendations of the ODG. The claimant underwent surgery on 10/06/11 and the ACL and PCL were intact. No loose bodies were identified and the menisci were intact. There was no instability of the ACL. was unable to find anything that could explain her mechanical symptoms. Furthermore, an MRI in April of 2012, post surgery, was reported to be negative There is no objective documentation provided to support a repeat MRI of the left knee. Therefore, the requested left knee MRI is not reasonable, medically necessary, or supported by the ODG and the previous adverse determinations should be upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)**