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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/30/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: CT arthrogram Rt knee

A 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for CT arthrogram Rt knee is not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO dated 08/16/13

Receipt of request for IRO dated 08/13/13

Utilization review determination dated 06/20/13

Utilization review determination dated 07/16/13

MRI of the right knee dated 11/04/08

MRI of the right knee dated 01/04/10

Radiographic report of the knee dated 02/09/10

Operative report dated 04/23/10

Clinical note dated 10/04/10

Clinical note dated 06/06/13

Letter of appeal dated 06/28/13

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. The available clinical record does not describe the mechanism of injury. The first available clinical note is an MRI dated 11/04/08. This study notes that the claimant is status post anterior cruciate ligament reconstruction. The appearance of the ACL grafts suggests reinjury. There appears to be a partial tear of the ACL graft. A full thickness tear is felt to be less likely. There is evidence of grade 2 chondromalacia patella. On 01/04/10, the claimant underwent a repeat MRI of the right knee. This study is reported to show a near complete to complete ACL tear. There is evidence for a chronic proximal LCL sprain without disruption and a marginal tear within the posterior horn of the lateral meniscus with degenerative changes within the posterior horn of the medial meniscus. On 04/23/10, the claimant was taken to surgery to undergo a revision of ACL reconstruction with tendon bone autograft, exploration of the tunnel, and harvesting of bone tendon autograft. This procedure was performed on 04/23/10. On 10/04/10, the claimant was seen in follow up. She is reported to be doing well and was happy with her knee. She

reports that her knee is more stable than it was before. Her preoperative pain is greatly diminished. Her current medications include Hydrocodone, Naproxen, and Flexeril. On physical examination, there is no medial and lateral joint line pain, no effusion, and good end point anterior drawer. There is a negative McMurray's and no patellar crepitus. Range of motion is measured as 0 to 110 degrees. On 06/06/13, the claimant was seen in follow up. He reports that the claimant was initially happy with her result and had a more stable knee and the swelling went down. She reports that recently she developed pain in her right knee and describes it as feeling like a pinched nerve. opines that the claimant could have some posttraumatic degenerative joint disease, ACL injury, and/or a possible element of lumbar radiculopathy.

She is reported to have seen a chiropractor 3 months prior which helped her. It was suggested that the claimant has elements of posttraumatic degeneration. On physical examination, she is noted to have positive medial and lateral joint line pain and positive patellar crepitus. Range of motion is 0 to 110. Anterior drawer is negative. McMurray's is negative. The claimant was subsequently recommended to undergo a CT arthrogram of the right knee and to be referred for x-rays of the right knee. The record includes a letter dated 06/28/13 in which he notes the initial reviewer was not an orthopedic surgeon. He recommended the study to determine the osteochondral integrity of the knee.

The initial review was performed on 06/20/13. The reviewer non-certifies the request noting that it is unclear what pathology remains under suspicion that would require evaluation by CT arthrography. He notes that it appears that degenerative joint disease is suspected. Degenerative joint disease should not require a CT arthrogram. He notes that the indications for CT arthrography are not evident in the notes available for review. The appeal request was reviewed on 07/16/13. At this time, the reviewer notes the prior denial. He notes that Official Disability Guidelines recommend an arthrogram of the knee when the patient has previously undergone a meniscal repair. He notes that there is no information submitted confirming that the patient has previously undergone a meniscal repair. As such, he finds that the request does not meet Official Disability Guidelines and subsequently upholds the prior denial.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Based upon review of the submitted clinical records, the claimant is a female with a history of 3 ACL reconstructions. The mechanism of injury is not described; however, it appears that the prior ACL disruptions resulted in a repeat ACL reconstruction performed on 04/23/10. The record does not contain any data to suggest an interval injury. Limited information is provided in his clinical notes. There is no indication in the clinical records that the claimant underwent meniscal repair in conjunction with ACL reconstruction. Based upon the data provided, Official Disability Guidelines have not been met and therefore, the prior utilization review determinations are upheld. As such it is the opinion of this reviewer that the request for CT arthrogram Rt knee is not 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)