

# Clear Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/06/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** MRI of the left knee

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Anesthesiology and Pain Medicine

**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 medical necessity for MRI of the left knee in this case is not established

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who sustained an injury on xx/xx/xx after performing walking at a fast pace. The patient had prior MRI in 01/12 which reportedly showed oblique tear of posterior horn of medial meniscus and insertional tear involving the central root of the posterior horn of the medial meniscus. The patient underwent left knee arthroscopy with ACL repair and lateral and medial meniscectomies with synovectomy and chondroplasty of the medial femoral condyle on 03/22/12. The patient was referred to post-operative physical therapy. Clinical record from 07/15/14 was handwritten and somewhat difficult to interpret due to handwriting and copy quality. No significant changes in symptoms were reported. In review of physical examination the left knee showed a 2 degree extension lag with flexion limited to 100 degrees in the left knee as compared to the right. Reflexes were 1-2+ in the lower extremities. There were positive McMurray signs in the left knee and positive Apley distraction sign. Positive Apley compression sign was noted in the left knee. There appeared to be a slightly positive anterior drawer sign. Physical therapy evaluation dated 07/16/14 noted the patient had continuing complaints of pain in the left knee with weight bearing and popping grinding and buckling. The patient favored the left lower extremity due to left knee pain. On physical examination there was notable atrophy involving the left quadriceps. There was gait antalgia involving the left lower extremity. There was loss of left knee range of motion with moderate weakness on muscle testing. The requested MRI of the left knee was denied by utilization review on 08/22/14 as there were no indications for repeat MRI as there was unclear rationale for significant sign or symptoms to support imaging. The request was again denied by utilization review on 09/10/14 as the patient should have been evaluated by an orthopedic physician and pending an evaluation MRI was not medically appropriate.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient was followed for persistent complaints of left knee pain following surgical intervention in 2012. The most recent evaluation of the patient noted substantial amount of functional deficit in the left knee. There continued to be loss of extension to 100 degrees and 2 degree extension loss of flexion in the left knee to 100 degrees with an extension lag of 2 degrees. There were positive McMurray and Apley distraction signs and positive Apley compression sign. Physical examination findings were noted by chiropractor office. Physical therapy evaluation also noted moderate weakness in the left knee with loss of range of motion and complaints of buckling popping grinding symptoms. No other evaluations were available for review including once from an orthopedic surgeon. Given the lack of any documentation from an orthopedic surgeon noting persistent functional impairments or positive orthopedic findings to support this request, it is the opinion of this reviewer that medical necessity for MRI of the left knee in this case is not established and the prior denials are upheld.

**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)