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DATE NOTICE SENT TO ALL PARTIES: Nov/04/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI right knee indirect Arthographic technique with contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, 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. At the at most this reviewer would only recommend a non-contrasted MRI study for the right knee as medically necessary. It is this reviewer's opinion the submitted request for a MRI the right knee with arthrographic technique and contrast is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX and was assessed with internal derangement of the right knee. Prior treatment had included the use of medications as well as physical therapy. The most recent MRI study of the right knee was from 08/09/13 which noted evidence of joint fusion and a baker's cyst with chondromalacia of the patella as well as mild lateral patellar subluxation. There was tendinosis of the popliteal tendons. The patient was followed through August 2015. The 08/21/15 evaluation noted persistent complaints of pain in the right knee. The patient's physical examination noted positive medial McMurray's signs for the right knee with intact strength and full range of motion. There was no evidence of varus or valgus instability; however, there was guarding with Lachman's sign.

The patient was recommended for a repeat MRI study of the right knee with an arthrographic type knee. The request was denied by utilization review on 08/25/15 as there were no exceptional factors noted in the clinical documentation to support repeat MRI studies. The request was again denied on 09/14/15 due to the lack of any significant findings.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for chronic complaints of right knee pain. MRI studies from 2013 found no significant pathology. The patient's more recent evaluations noted positive medial McMurray's signs as well as some progression of guarding with Lachman's testing to the right knee. No varus or valgus instability was evident. Through 08/21/15 the clinical records noted persistent moderate to severe right knee pain with some development of guarding with Lachman's testing. Given that the patient's last MRI study of the right knee is now over two years old and the patient has persistent right knee symptoms, a repeat MRI study of the right knee would be appropriate and medically necessary within Official Disability Guidelines recommendations. Per Official Disability Guidelines arthrography techniques are recommended for as a post-operative all option to help diagnose suspected residual recurrent tears. To date this patient

has not undergone any surgical intervention that would support MR arthrography techniques. At the at most this reviewer would only recommend a non-contrasted MRI study for the right knee as medically necessary. It is this reviewer's opinion the submitted request for a MRI the right knee with arthrographic technique and contrast 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)