

Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727

PH: (512) 705-4647
FAX: (512) 491-5145
IRO Certificate #4599

DATE OF REVIEW: 6/02/16

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRI, Left Knee, CPT 73721

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

Physician Board Certified in Physical Medicine & Pain Management

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overtured (Disagree) X

Partially Overtured (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY

Patient is a female with history of 2 prior knee reconstructions in XXXX and XXXX of the right knee, who was injured in XX/XXXX when she fell on a wet floor. On X/X/XXXX, she saw XX and complained of bilateral knee pain. She reported pain in the posterior and medial right knee and lateral left knee. Left knee exam at that time was reported as normal. X-ray of the left knee showed patellofemoral compartment narrowing, bilateral knee braces were dispensed, and bilateral knee steroid injections were given. Due to bloody aspiration during the cortisone injections, a STAT MRI of the right knee was ordered. MRI of the right knee on X/X/XX showed an ACL graft tear with anteromedial tibial epiphysis and metaphysic bone bruise and medium sized joint effusion, moderate to severe patellar medial facet and apical chondromalacia. On X/X/XX, she followed up and complained of 10/10 bilateral knee pain. MRI of the left knee was recommended as was a right knee arthroscopic surgery. The right knee surgery was approved. Physical therapy for 8 sessions was denied. Denial note mentions that McMurray's test was possibly positive as reported during a peer to peer phone conversation. Letter from XX mentions that she feels like there is something tearing on the outside of her left knee. She also mentions that she would need a strong left knee to rehab the right knee and that an MRI of the left knee would ideally be done prior to her right knee surgery to identify any potential surgical pathologies to minimize the number of surgeries she has to have and presumably exposure to anesthesia.

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

Opinion: I disagree with the benefit company's decision to deny the requested service.

Rationale: This review pertains to the need for a left knee MRI. Per ODG knee MRI is indicated if internal derangement is suspected and x-rays are non-diagnostic. The patient had substantial enough fall to cause an ACL graft tear and chondral bruising as evidenced on the right knee MRI. It would be expected that a similar amount of force impacted the left knee during the fall. Clearly, the right knee, with her previous surgeries, was more vulnerable and, therefore, ended up with more severe injury and symptoms but that does not negate the symptoms she has on the left side. The claimant has been consistent with her complaints of bilateral knee pain and more specifically, lateral left knee pain. Physical therapy for the knees has been denied and conservative management, in the form of cortisone injections and passage of

time, clearly, did not help her pain and symptoms. She will likely need post-surgical physical therapy, and the pain the in the left knee will impact her function and ability to rehab.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)