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Notice of Independent Review Decision

DATE OF REVIEW: April 16, 2009

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the bilateral knees

REVIEW OUTCOME

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

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an industrial injury on xx-xx-xx which resulted in bilateral knee pain. The patient had reportedly been assisting a resident who pushed against her and her knee popped. She had joint line pain immediately and continued to have bilateral knee pain.

A September 22, 2006 left knee MRI revealed abnormal appearance of the medial meniscus with horizontal cleavage plane/meniscal tear and perimeniscal cyst/cysts. Small joint effusion, no bone marrow edema or fracture, and no ligamentous tear were identified.

She was seen on October 10, 2006 and she stated that she had a prior right knee arthroscopy. On October 24, 2006, a diagnostic arthroscopy of the left knee and arthroscopic partial medial meniscectomy was performed. On November 3, 2006, the patient stated that she was down to utilizing one crutch. She reported increased discomfort in the right knee which localized to the medial joint line. The recommendation was made that the patient utilize both crutches and go to physical therapy.

In December 2006, it was noted that the patient did have a history of prior right knee injury from 2003 with a meniscectomy.

X-rays of the right knee were normal. An MRI of the knee was recommended. A right knee MRI was performed on December 6, 2006 and indicated a prior partial medial meniscectomy with findings consistent with recurrent or residual undersurface oblique tear in the posterior body and posterior horn of the medial meniscus. There was a 16 x 13 x 5 mm juxtacortical nodule at the lateral epicondyle. It was noted to be a probable sessile osteochondroma. Following the MRI, the patient was injected. Her left knee was noted to have no effusion and good range of motion.

The patient underwent Supartz injections to the left knee and right knee arthroscopy was recommended in March 2007. On March 22, 2007, diagnostic arthroscopy of the right knee was performed with revision partial medial meniscectomy, articular cartilage debridement with abrasion chondroplasty of the medial femoral condyle. The postoperative diagnosis was right knee medial meniscal tear with findings of grade 2-3 chondromalacia involving the medial aspect of the weight-bearing surface of the medial femoral condyle. Shortly following surgery, the patient noted that she was doing well and she continued with Supartz injections to the left knee.

In May 2007, the patient reported hypersensitivity with the anterior aspects of both knees and a diagnosis was made of the development of a mild regional complex pain disorder. Continuation of aquatic therapy and a trial dose of Lyrica were recommended. She began work hardening in August 2007 on the basis of a functional capacity evaluation that found that she was not able to meet the requirements of her job.

A supplemental designated doctor report, dated August 17, 2007, states that the patient qualified for the medium work category based on the FCE and his evaluation. She was not deemed to be at maximum medical improvement. By September 7, 2007, it was noted that she can return to her position. On November 16, 2007, she again saw the designated doctor and was noted to have reached clinical MMI with a 2% whole person impairment.

On May 20, 2008, she saw another physician for an initial examination. She reported a pain scale of 7-8/10 with a sensation of numbness and tingling, mostly in the left anterior aspect of the left knee. Examination showed allodynia and hyperpathia. Range-of-motion was found to be normal. The diagnoses were bilateral knee meniscal tears status post surgical repair and neuropathy likely secondary to saphenous nerve neuropathy. In September 2008, she reported persistent problems with hypersensitivity and pain in the medial peripatellar tissues, consistent with saphenous neuritis. Lyrica was found to not be helping. The examination did not show effusion. Flexion was to about 120 degrees. X-rays were performed and showed no degenerative change. The joint spaces were well maintained. An increased dosage of Lyrica was recommended. In October 2008, the patient underwent an EMG/NCV which was found to be normal.

The patient presented on November 10, 2008 for a reevaluation. The patient was taking Lyrica for neuropathic pain. She has complaints of hypersensitivity in a saphenous distribution, which has been aggravated by work duties. Physical examination findings included normal range of motion of the knees bilaterally with no apparent effusion. Tenderness was noted with light touch along the medial aspect of both knees radiating into the calves.

She was examined on December 31, 2008 with complaints of left greater than right knee pain and associated swelling. The report states that the patient has a history of prior work-related meniscal tears and some chondromalacia in the right knee. The symptoms seem to be localized to the joint lines and an MRI was recommended to check the status of her cartilage.

A peer review report, dated February 26, 2009, provides an opinion that once the bilateral knee surgeries were accepted as work-related, then the maintenance follow-up visits and treatment were reasonable. Treatment for the saphenous neuritis, in all probability, has not been related to the work injury and/or resultant surgery, according to the physician. The physician also stated that there is no support for repeat MRIs at this time. He stated that the exam findings do not correlate with medical necessity for repeat MRIs. The claimant had known chondromalacia in the right knee per the 2007 operative report. He stated that it is not probable that this disease of life would be related to the left knee injury on September 12, 2006, nor subsequent left knee or repeat right knee surgery. He stated that it is more probable that this finding of chondromalacia pre-existed the 2006 work event.

The request for bilateral knee MRIs was non-certified in March 2009 as there was insufficient clinical documentation to indicate that the patient had sustained a recent trauma to either knee. Additionally, there were no submitted radiographs that were equivocal for pathology or demonstrate joint effusion in the knees bilaterally.

The request was again non-certified by another reviewer later in March 2009. The reviewer stated that there is no requisite plain film analysis. The knees have been extensively evaluated with imaging and arthroscopic studies, and it is not clear how additional imaging studies would help the treatments.

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

There is no indication in the medical records that the patient has sustained a new acute trauma to the knee. However, the guidelines state that for non-traumatic knee pain in adults, an MRI may be indicated if x-rays demonstrate normal findings or a joint effusion. The most recent x-rays did not reveal degenerative changes and revealed well-maintained joint spaces. The

patient continues to complain of symptoms that the physician described as localized to the joint lines. The guidelines state that an MRI may be indicated if internal derangement is suspected. Arthroscopic surgery was last performed in March 2007. Prior to that, an MRI had revealed the possibility of an osteochondroma on the right side. There was no mention of the osteochondroma in the operative report of March 2007.

Based on the recent normal x-rays, continued symptoms, date of the last arthroscopic surgery, and presence of osteochondroma upon previous MRI, bilateral repeat MRIs are medically necessary at this time. Therefore, my determination is to overturn the decision to non-certify the request for an MRI of the bilateral knees.

The IRO's decision is consistent with the following guidelines:

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

__X__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

Official Disability Guidelines/Knee Chapter:
MRI's (magnetic resonance imaging)
Recommended as indicated below. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MRI. (ACR, 2001) See also ACR Appropriateness Criteria. Diagnostic performance of MR imaging of the menisci and cruciate ligaments of the knee is different according to lesion type and is influenced by various study design characteristics. Higher magnetic field strength modestly improves diagnostic performance, but a significant effect was demonstrated only for anterior cruciate ligament tears. (Pavlov, 2000) (Oei, 2003) A systematic review of prospective cohort studies comparing MRI and clinical examination to arthroscopy to diagnose meniscus tears concluded that MRI is useful, but should be reserved for situations in which an experienced clinician requires further information before arriving at a diagnosis, and indications for arthroscopy should be therapeutic, not diagnostic in nature. (Ryzewicz, 2007) This study concluded that, in patients with nonacute knee symptoms who are highly suspected clinically of having intraarticular knee abnormality, magnetic resonance imaging should be performed to exclude the need for arthroscopy. (Vincken, 2007) In most cases, diagnosing osteoarthritis with an MRI is both

unnecessary and costly. Although weight-bearing X-rays are sufficient to diagnose osteoarthritis of the knee, referring physicians and some orthopaedic surgeons sometimes use magnetic resonance imaging (MRI) either with or instead of weight bearing X-rays for diagnosis. For total knee arthroplasty (TKA) patients, about 95% to 98% of the time they don't need an MRI. Osteoarthritis patients often expect to be diagnosed with MRIs, and this demand influences MRI use. Average worker's compensation reimbursement is also higher for the knee MRI ($664) than for the knee X-rays ($136). (Goldstein, 2008)
Indications for imaging -- MRI (magnetic resonance imaging):
- Acute trauma to the knee, significant trauma (e.g, motor vehicle accident), suspect posterior knee dislocation.
- Nontraumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed.
- Nontraumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary, and if internal derangement is suspected.
- Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected.
- Nontraumatic knee pain, adult - nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Peligrini Stieda disease, joint compartment widening).