

SENT VIA EMAIL OR FAX ON
Apr/21/2009

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/16/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Knee MRI, MR Arthrogram / Arthrography (with injections), and X-Rays 2 views (Lateral and Sunshine)

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

Chiropractor

AADEP Certified

Whole Person Certified

TWCC ADL Doctor

Certified Electrodiagnostic Practitioner

Member of the American of Clinical Neurophysiology

Clinical practice 10+ years in Chiropractic WC WH Therapy

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 3/13/09 and 3/11/09

Dr. /4/09

Dr. 3/3/09

OP Report 12/16/08

MRI 8/11/04

Dr 10/29/04 thru 1/31/07

PATIENT CLINICAL HISTORY SUMMARY

The injured worker was injured on xx-xx-xx as a result of a work related knee injury. The injured employee underwent therapy and eventually a right knee debridement and meniscectomy with little relief. The injured employee underwent a cortisone injection which was helpful for several months. The injured employee underwent post-op therapy and HEP. On December 16, 2008 a caudal epidural catheter placement with injection of epidural steroid at L5-S1 on the right side due to right lower extremity swelling allodynia, sweating. Dr. has recommended a right knee MR arthrogram. It is noted that the last MR was pre-operative on 8-11-04. Physical examination findings on 3-04-2009 revealed ROM 10-degrees extension, 90-degrees flexion, crepitus, pain 7/10, muscle weakness, laxity to Drawer Test, and ACL laxity. MRI report dated 8-11-2004 indicate medial meniscal tear.

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

After a careful review of all medical records, the Reviewer's medical assessment is that the request is medically necessary. As stated above, the injured employee fits all the OD Guideline criteria. Please see the criteria below.

MR arthrography Recommended for meniscal repair and meniscal resection of more than 25%. All patients with meniscal repair required MR arthrography. All patients with meniscal resection of more than 25%, who did not have severe degenerative arthrosis, chondral injuries, or avascular necrosis required MR arthrography. Patients with less than 25% meniscal resection did not need MR arthrography. (Magee, 2003)

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).

Radiography (x-rays) Recommended. In a primary care setting, if a fracture is considered, patients should have radiographs if the Ottawa criteria are met. Among the 5 decision rules for deciding when to use plain films in knee fractures, the Ottawa knee rules (injury due to trauma and, tenderness at the head of the fibula or the patella, inability to bear weight for 4 steps, or inability to flex the knee to 90 degrees) have the strongest supporting evidence. A negative result on an Ottawa knee rule test accurately excludes knee fractures after acute knee injury. The pooled negative likelihood ratio is 0.05, the pooled sensitivity is 98.5%, and the pooled specificity is 48.6%. (Bachmann, 2004) (Jackson, 2003) In an emergency room setting, in patients of any age except for infants, the clinical parameters used for not requiring an x-ray following knee trauma are as follows: Patient is able to walk without a limp, and Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee x-rays in this population following trauma are as follows: Joint effusion within 24 hours of direct blow or fall, Palpable tenderness over fibular head or patella, Inability to walk (four steps) or bear weight immediately or in the emergency room or within a week of the trauma, and Inability to flex knee to 90 degrees. Normal x-ray results can be expected in the absence of immediate swelling, ecchymosis, deformity, increased warmth, or abrasion/laceration. A fracture can be excluded if the single lateral view of the knee is normal, eliminating the need for additional radiographic views. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MR. In addition to MR, single photon emission computed tomography (SPECT) has also been reported to be accurate for diagnosing meniscal injuries, while sonography has been shown to be diagnostic for acute anterior cruciate ligament (ACL) injuries in the presence of a hemarthrosis or for follow-up. (ACR, 2001) (Pavlov, 2000) (Goergen, 2000) Studies have suggested that the symptoms of knee osteoarthritis (OA) are rather weakly associated with radiographic findings and vice versa. Based on a review of all studies, the proportion of those with knee pain found to have radiographic osteoarthritis ranged from 15-76%, and in those with radiographic knee OA the proportion with pain ranged from 15% - 81%. The results of knee x rays should not be used in isolation when assessing individual patients with knee pain. (Bedson, 2008) See also ACR Appropriateness Criteria™

Indications for imaging -- X-rays

- Acute trauma to the knee, fall or twisting injury, with one or more of following: focal tenderness, effusion, inability to bear weight. First study

- Acute trauma to the knee, injury to knee \geq 2 days ago, mechanism unknown. Focal patellar tenderness, effusion, able to walk

- Acute trauma to the knee, significant trauma (e.g, motor vehicle accident), suspect posterior knee dislocation

- Nontraumatic knee pain, child or adolescent - nonpatellofemoral symptoms. Mandatory minimal initial exam. Anteroposterior (standing or supine) & Lateral (routine or cross-table)

- Nontraumatic knee pain, child or adult: patellofemoral (anterior) symptoms. Mandatory minimal initial exam. Anteroposterior (standing or supine), Lateral (routine or cross-table), & Axial (Merchant) view

- Nontraumatic knee pain, adult: nontrauma, nontumor, nonlocalized pain. Mandatory minimal initial exam. Anteroposterior (standing or supine) & Lateral (routine or cross-table). (ACR,

2001) (Pavlov, 2000)

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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