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Notice of Independent Review Decision

DATE OF REVIEW: January 27, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee arthrogram with MRI 73722

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

Fellow American Academy of Orthopaedic Surgeons

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Imaging

- Office Notes (08/09/10 - 10/06/10)
- Radiodiagnostic study (09/16/09 – 01/08/10)

- Office Notes (10/12/09 - 10/06/10)
- Radiodiagnostic study (09/16/09 – 01/08/10)
- Designated doctor evaluation (01/21/10)
- Utilization Reviews (11/19/10, 12/13/10)
- IRO Request

TDI

- Utilization Reviews (11/19/10, 12/13/10)
- IRO Request

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male employee of, who fell off a truck about 12-15 feet and hit the ground on xx/xx/xx. He sustained injury to his left knee, right ankle, right shoulder, elbow, wrist, and neck.

Following the injury, the patient went to Medical Center emergency room (ER) where his leg was placed in a cast and started on medications. X-rays of the right wrist revealed a comminuted, impacted fracture of the distal radius with an associated avulsion fracture of the ulnar styloid, proximally rotated and volarly displaced (largest volar fracture fragment approximately 9 mm), widening of the radial ulnar interval and extensive soft tissue swelling surrounding the wrist. X-rays of the right elbow were unremarkable. X-rays of the right forearm showed comminuted intra-articular fracture of the distal radius with dorsal angulation of the distal radial articular surface and significant articular incongruity. Postreduction x-rays again demonstrated a severely comminuted distal radial fracture and ulnar styloid process fracture, not significantly changed from the prior examination. The patient underwent open reduction internal fixation (ORIF) of the distal radius fracture on September 24, 2009.

M.D., placed the right wrist in a short-arm cast. M.D., managed him with medications including hydrocodone and ibuprofen. The patient attended postoperative physical therapy (PT).

In a physical performance evaluation (PPE), he was found not to meet the requirement for full duty status and was recommended active PT.

In January 2010, he underwent various diagnostic studies. Magnetic resonance imaging (MRI) of the left knee revealed grade III patellar chondromalacia, grade IV chondromalacia along the central articular surface of the femoral trochlea, small joint effusion, mild distal patellar tendinitis, grade III chondromalacia along the weightbearing surfaces of the medial femoral condyle and medial tibial plateau and horizontal cleavage tear of the body of the medial meniscus with tear extending to the superior surface in the middle one-third of the meniscus. MRI of the right ankle revealed subacute, nondisplaced, osteochondral impaction fracture along the lateral weightbearing surface of the talar dome; small chronic osteochondral defect along the medial weightbearing surface of the talar dome, likely a focus of osteochondritis dissecans; bony and cartilaginous defect measuring 8x 9 mm and small ankle and posterior subtalar joint effusions. MRI of the right elbow showed acute medial epicondylitis with edema and inflammatory changes surrounding the common flexor tendon extending from humeral attachment distally over a length of 2 cm and joint effusion. MRI of the right shoulder showed mild distal supraspinatus tendinosis, minimal degenerative hypertrophy of the AC joint and joint effusion. MRI of the cervical spine showed a 2-mm posterior central disc protrusion at C5-C6 and C6-C7, minimal degenerative spondylosis at C4-C5, C5-C6, and C6-C7.

M.D., a designated doctor, diagnosed fracture of the distal radius, knee and ankle sprain/strain, elbow medial and lateral epicondylitis, shoulder sprain/strain, cervical disc syndrome and cervical radiculitis. He opined the extent of injury included all of the aforementioned areas specifically the cervical spine, right shoulder, right elbow, right forearm, wrist or hand, left knee and the right ankle. With regards to the disability, he stated this was the direct result of the work-related injury.

In August 2010, , D.C., from Rehab noted that the complaints in left knee were decreasing after initiating active rehab while the patient continued to have pain in his right ankle, right shoulder, forearm and elbow. Examination revealed mild tenderness in the right AC joint with restricted shoulder range of motion (ROM), tenderness along the medial and lateral epicondyles of the right elbow and limited ROM and positive supraspinatus test. Cervical spine examination showed spasms in the bilateral paraspinals, restricted ROM and positive foraminal compression and shoulder depression on the right. Left knee examination showed tenderness along the lateral aspect, restricted ROM and positive valgus stress test. There was tenderness along the lateral aspects of the right ankle with decreased strength and functional ability. Dr. recommended continuing active rehab and evaluation by Dr. for orthopedic evaluation of the cervical spine.

M.D., noted the patient had slight improvement with regards to his musculoskeletal complaints but he continued to have right ankle pain, cervical pain and spasms on the left side and left knee pain. He noted the following: Upper extremity electrodiagnostic studies in March 2010 showed right carpal tunnel syndrome (CTS), right ulnar neuropathy across the elbow and right-sided C7 radiculitis. MRI of the right wrist in May 2010 showed remote ORIF with grade I tenosynovitis, mild degenerative hypertrophy and radial and ulnar joint fusion. The patient was status post left knee arthroscopic surgical repair on May 3, 2010. Currently, the patient was utilizing Soma and ibuprofen. Examination of the cervical spine showed painful ROM and paraspinal muscle spasms on the left side with trigger points. Right handgrip strength was decreased to 4/5 and there was tenderness over the right shoulder/deltoid region. There was slight pain in the left knee with well-healing arthroscopic scars. Tenderness was noted in the right dorsal/lateral ankle with decreased ROM and strength. Dr. recommended electrodiagnostic studies of the lower extremities and continuation of Soma.

In October 2010, M.D., an orthopedic surgeon, noted effusion in the left knee joint, positive McMurray's test and medial joint line tenderness. Right shoulder examination showed decreased ROM and positive impingement and O'Brien tests. He assessed right shoulder labral tear and status post wrist and left knee surgery. He ordered MR arthrogram of the right shoulder and left knee and continued off work.

M.D., evaluated the patient for right ankle pain which seemed to be better with Mobic. There was tenderness over the anterior aspect of the ankle and medial and lateral malleoli, trace effusion, limited ROM and pain with inversion and eversion of the foot/ankle. Dr. suspected posterior arthritis of the right ankle, placed him on Mobic and Prilosec and recommended consultation with Dr. or Dr..

On November 19, 2010, the request for MR arthrogram of the right shoulder and left knee was denied with the following rationale: *"The clinical documentation indicates the patient underwent a prior MRI of the left knee and right shoulder; however, the independent studies were not submitted for review to assess the patient's pathology. There is a lack of documentation of any recent conservative care of the patient's right shoulder and/or left knee symptoms. There is also no indication provided as to why the patient would be requiring an MR arthrogram*

versus standard MRI studies. As such, the documentation provided does not support the certification of the request.”

On December 7, 2010, Dr. submitted an appeal for MR arthrogram of the left knee.

On December 13, 2010, an appeal for left knee arthrogram with MRI was denied with the following rationale: *“The patient is stated to have undergone a prior surgical intervention to the left knee in May 2010; however, no operative reports were submitted for review. No prior imaging before the patient’s left knee surgery was submitted for review. The patient does have positive McMurray’s findings; however, it is unclear from the patient’s most recent physical exam if these findings are of a new or sudden onset that would reasonably require additional imaging studies of the left knee. As such, medical necessity is not supported at this time.”*

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

The patient’s treating physician, Dr. has submitted a request as well as an appeal for an MR arthrogram. As noted by the prior reviewers, the patient is noted to have had left knee arthroscopic surgery in May 2010. There are no operative notes for review to determine what procedure was done. There is no recent x-ray or radiographic report of the patient’s knee. According to ODG Guidelines, an MR arthrogram is indicated in patients who have had meniscal tear or meniscal resection of greater than 25% who do not have degenerative arthrosis, chondral injuries, or avascular necrosis. There is no documentation to support that the patient has had any of these conditions.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**