CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 7-27-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat left knee MRI

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

Board Certified in Occupational Medicine
American Board of Preventive Medicine

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MD., office visits on 12-13-10, 1-20-11, 2-18-11, 3-18-11, 4-14-11, and 5-12-11.
- 1-7-11 Surgery performed by MD.
- MD., office visits on 3-24-11, 4-27-11.
- 5-13-11 Functional Capacity Evaluation.
- 6-20-11, MD, performed a Utilization Review.
- 6-23-11 DC. Letter of Medical Necessity.
- 6-30-11 DO., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

12-13-10 MD., the claimant is scheduled to undergo surgery on 1-7-11. He is still unable to fully carry out his activity of daily living due to pain.

1-7-11 Surgery performed by MD: Partial meniscectomy, abrasion chondroplasty of patella with Coblation.

1-20-11 MD., the claimant reports tenderness due to recent surgery on 1-7-11. The claimant is ambulating ith a walking cane. The claimant is to continue with pharmaceutical management, continue with Dr, and return in four weeks. Remain off work.

2-18-11 MD., the claimant still has difficulty with ambulation. The claimant is to continue with postop physical therapy. The claimant is referred for pharmaceutical management, follow up with Dr., and remain off work.

3-18-11 DC., the claimant has increased muscle strength and endurance. He still has tenderness at his left knee joint upon walking and weight bearing along the medio anterior aspect. The claimant has ongoing with aquatic therapy. The claimant is to continue with Dr. continue with Dr. and return in four weeks. Continue with aquatic therapy.

3-24-11 MD., the claimant reports that the recent medication changes and physical therapy improved the quality of life and pain control. Range of motion shows full range of motion and extension. The claimant is to continue with physical therapy with Dr. He is doing pool therapy. The claimant is to continue with Ibuprofen. UDS is consistent with medications given.

4-14-11 DC., the claimant reports mild locking of the knee along with sharp pain. He reports his ongoing aquatic therapy is improving him tremendously. He is taking Ibuprofen 800 mg and is helping him tremendously. On exam, the claimant has flexion 132 degrees and extension of -5 degrees. There is tenderness at the left joint upon palpation. There is decreased muscle strength. Positive valgus/varus stress test, McMurray test. The claimant is to continue with Dr. Dr. return in 4 weeks, remain off work, and continue with aquatic therapy 3 x weeks.

4-27-11 MD., the claimant has a history of myofascial pain syndrome and knee pain who presents for medication review and follow up. Physical therapy has improved his quality of life and his pain control significantly. The claimant takes Ibuprofen 800 g and Tramadol. On exam, the claimant has full flexion and full extension. Right knee range of motion is normal with full extension and full flexion. The claimant has mild pain with palpation along the medial aspect of the left knee and some pain in the left quadriceps muscle. Assessment: Chronic pain syndrome, knee pain, myofascial pain. Plan: the claimant should discontinue Tramadol since it is causing urinary retention. She was given a prescription for Nucynta, Voltaren gel, continue physical therapy as planned.

5-12-11 DC., the claimant is reporting feeling better at this time. He noticed improvement with walking and endurance. However, he is complaining of tenderness at the left knee joint with increased in tenderness upon prolonged walking. He is grading his pain at 5/10. He has completed his aquatic therapy with good results. On exam, he has a positive valgus/varus test, positive McMurray's test. The evaluator recommended follow up with Dr., follow up with Dr. return in four weeks, remain off work, recommended Functional Capacity Evaluation, continue pharmaceutical management.

5-13-11 Functional Capacity Evaluation shows the claimant should be placed in a chronic pain management program. The claimant is functioning at a Light Medium PDL.

6-20-11 MD, performed a Utilization Review. The request for repeat left knee MRI is non-certified. The documentation submitted for review elaborates the patient complaining of ongoing left knee pain with associated range of motion limitations. Evidence based guidelines recommend a repeat MRI of the knee provided the patient meets specific criteria. No documentation was submitted regarding the need to assess knee cartilage tissue repair. Given the lack of documentation regarding the patient's need for assessing the cartilage in the left knee, this request does not meet guideline recommendations. As such, the documentation submitted for this review does not support this request at this time. Determination: Non-Certified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, the request for repeat left knee MRI is non-certified.

Addendum: Additional documentation was submitted for review on 6-20-11 at 4:34 pm CST, to include the patient's previous MRI dated 1-7-11 and therapy notes dated 2-8-11 through 3-3-11. However, as no information was submitted regarding the need to further assess the patient's cartilage of the left knee, the determination remains unchanged as non-certified.

6-23-11 DC., Letter of Medical Necessity - The claimant is under my care for the work related injury that he sustained. The patient sustained injury to his left knee joint. The patient had MRI of the left knee joint on xx/xx/xx and the result shows that there is a 1) Bucket-handle medial meniscal tear, 2) Interstitial sprain/partial tear of the anterior cruciate ligament (ACL), 3) Grade II MCL sprain and Grade II conjoined tendon and fibular collateral ligament sprains and 4) Large post-traumatic reactive joint effusion with post-traumatic soft tissue contusion over the anterior joint line. The claimant had surgery of the left knee joint on 1-7-11 with Dr., MD. for repair of the above pathological findings. The patient has completed his post-surgical physical therapy which included land-based and aquatic. The patient made a tremendous amount of improvement with his muscle strength and endurance. However, he is complaining of sharp tenderness at his left knee joint along the medial aspect. There is an increased in tenderness upon walking and weight bearing, especially upon walking up and down an inclined surface. There is a moderate amount of swelling noted at the left knee joint. There is still a decreased in range of motion noted. Limping is noted upon gait analysis. The patient is still exhibiting a less than favorable condition. Therefore, at this time, she was requesting for a post-surgical MRI of the left knee to determine the underlying pathology.

6-30-11 DO., performed a Utilization Review. As per report dated 6-23-11, the patient complains of sharp tenderness along the medial aspect of the left knee with increased tenderness upon walking and weight bearing. The examination revealed limping gait, moderate swelling, and decreased ROM. He was noted to have positive valgus/varus stress and McMurray's tests and decreased strength in the left lower extremity per 5-12-11 report. This is an appeal for the request for repeat left knee MRI to determine the underlying pathology. However, the previous MRI report is not provided for review. Any recent plain radiograph is also not included in the submitted records. There is no indication seen in the records that there is need to assess knee cartilage repair tissue. Apparently, the patient had completed physical therapy. However, there are no PT reports provided for review to objectively document patient's response and to validate the number of sessions attended. It was discussed with Dr. that there were no documented post op events that would lead to concern, and there are not objective signs documented. Hence, the request is not substantiated at this time. Determination: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this appeal for the request for Repeat Left knee MRI is non certified.

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

FROM MY REVIEW, IT APPEARS THAT THE POSITIVE MCMURRAY AND VALGUS/STRESS TESTS WERE PRESENT FROM THE FIRST TIME IT WAS TESTED ON 3/18/11 AND WAS NOTED ON MOST ALL LATER EXAMINATIONS. NOW WITH THE NEW LOCKING SENSATION REPORTED BY THE PATIENT, THERE MAY BE STILL SOME TYPE OF INTERNAL DERANGEMENT, CARTILAGE REPAIR ISSUES. THEREFORE, A REPEAT MRI OF THE LEFT KNEE IS MEDICALLY APPROPRIATE AND NECESSARY AND INDICATED AS IS NOTED BY ODG, SEE REPEAT MRI INDICATIONS.

ODG-TWC, last update 6-13-11 Occupational Disorders of the Knee - MRI:
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 further information is required for 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) Repeat MRIs are recommended if need to assess knee cartilage repair tissue. In determining whether the repair tissue was of good or poor quality, MRI had a sensitivity of 80% and specificity of 82% using arthroscopy as the standard. (Ramappa, 2007) MRI scans are accurate to diagnose meniscus tears, but MRI is a poor predictor of whether or not the tear can be repaired. Surgeons cannot tell whether the tear will be reparable until the surgery is underway, and it affects recovery because repaired meniscus tears have a more involved recovery compared with surgical removal of the tissue. (Bernthal, 2010) In this case series, in more than half of patients who had an MRI at the request of their referring physician, the MRI was not necessary. MRI was considered unnecessary if: X-rays alone could establish the diagnosis, patellofemoral pain with a normal ligamentous and meniscal exam, the knee pain resolved before seeing an orthopedic surgeon, or the MRI findings had no effect on treatment outcome. MRI studies were deemed necessary if they were indicated by history and/or physical examination to

assess for meniscal, ligamentous, or osteochondral injury or osteonecrosis, or if the patient had an unexpected finding that affected treatment. (Khanuja, 2011)
Indications for imaging -- MRI (magnetic resonance imaging):
- Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption.
- 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).
- Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Ramappa, 2007)

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**

☒ **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)**