



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WCN

DATE OF REVIEW: 11-11-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI right lower leg, non joint calf area 73721

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

American Board of Orthopaedic Surgery-Board Certified

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

- 4-12-11 X-rays of the right tibia and fibula.
- 5-26-11 Physical therapy note.
- 6-30-11 DO., performed Designated Doctor Evaluation.
- 7-12-11 MRI of the right ankle.
- 7-12-11 MRI of the right leg/knee.
- 7-25-11 MD., office visit.
- 8-24-11 MD., office visit.
- 9-21-11 MD., office visit.
- 9-27-11 MD., Utilization Review.
- 10-5-11 OPAC/ MD., office visit.
- 10-14-11 MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

4-12-11 X-rays of the right tibia and fibula was normal.

5-26-11 Physical therapy note.

6-30-11 DO., performed Designated Doctor Evaluation. He certified the claimant had not reached MMI. It was his opinion that the claimant suffered a soft tissue injury to his right calf area xx/xx/xx and persists with discomfort to the area. Today he spoke with ins. adjuster to obtain more medical records but he has none. He reports the Nurse Case Manager is in possession of all records and has not submitted them to , Mr. states some sort of network SNAFU has prevented authorization of an MRI earlier, however, that has since been resolved and the MRI has been authorized. At this point he could not make an MMI or IR assessment.

7-12-11 MRI of the right ankle was unremarkable.

7-12-11 MRI of the right leg/knee was unremarkable. No acute muscle injury identified.

7-25-11 MD., the claimant is a gentleman who injured his right leg while pushing a very heavy tailgate on a truck back in xx and it felt like somebody hit him in the back of the calf with a baseball bat. He tried to go ahead and complete the work that he had there for him that day. Finally by the time he got back to the shop. He had quite a substantial amount of swelling and actually significant bleeding and bruising noted. He was sent to the emergency room where Doppler was done to rule out DVT and he has been off work trying to perform therapy to try to improve. He has had some improvement in pain but still has pain in the calf muscle. He has difficulty with being on his feet for extended period of time and is released back to work at light duty where they had him do quite a bit of walking and he is not able to tolerate that. Objective Findings: MRI was ultimately performed several months after his injury which basically was a negative study without any acute injury noted. On physical exam, he has tenderness in his posterior medial calf region with resisted plantarflexion. No real pain with resisted dorsiflexion. He does have pain with resisted inversion of the foot and less so with resisted eversion. There is no true palpable defect but he feels there is actually tenderness over the posterior tibialis muscle belly and has noted palpable defect in the gastrosoleus complex. Achilles tendon appears to be intact. Impression: Chronic calf strain. Plan: He felt the patient needs to have some further time for healing, so he did fill out a 73 Form to continue off work. He asked him to get a calf sleeve to continue some home stretching and exercise regimen that he has been given due to further physical therapy being denied. We would like to see him back in about at month to see if things are progressing to the point where he can return back to work full duty. It may be still several months' process of healing. The patient has been seen by another orthopedic physician in the past but at this point he would like to follow up with him. He will see him back in one month for rehab check.

8-24-11 MD., the claimant complains of right lower extremity pain. He has been placed off work by his physician. He was seen by a Designated Doctor who did not have adequate medical records to determine MMI. On exam, the claimant is climbing while walking an antalgic gait. Diagnosis: Chronic calf strain right leg. He was continued off work. He purchased a calf sleeve that helped until he resumed work. He was sent to the ER this past week with heat stroke. The evaluator felt the claimant had been dealt with unfairly. He has not had adequate time to heal. He is denied further therapy and required to work in poor working conditions. He should have a new Designated Doctor Evaluation for MMI to be determined. Adequate medical records should be provided.

9-21-11 MD., the claimant continues with right calf pain with ambulation. He uses a cane as well as a calf sleeve with minimal benefits. Off work now, not improving. No active medications. Diagnosis: Contusion of leg unspecified. Plan: Repeat MRI to look for chronic calf strain/tear.

9-27-11 MD., UR non certification for repeat MRI right lower leg, non joint calf area. The patient presently complains of right calf pain with ambulation. This is a request for repeat MRI of the right lower leg, non joint calf area. However, the recent medical report dated 09/21/11 did not include a comprehensive physical and neurologic examination. PT progress reports stating the patient's functional improvement/non-improvement were

likewise not submitted. Finally, the patient's recent MRI of the right knee and lower leg did not reveal any abnormalities. The rationale for requesting a repeat MRI of the right lower leg is not clear. Hence, the necessity of the above request cannot be established at this time.

10-5-11 OPAC/ MD., the claimant continues with complaints of right calf pain. He states that he is unable to ascend or descend stairs. He reported that 30, minutes at Wal-Mart is extremely painful. He is frustrated and angry that he cannot have a repeat MRI to assist in finding out what is going on. On exam, the right gastroc muscle is painful with pain to the mid calf. This appears to be deep in the area of the soleus versus the gastrocnemius. Girth measurements showed right at 38 cm and left at 39.5. DTR were 2/4 bilaterally. Diagnosis: Contusion of leg. The evaluator reported he could not think of anything else other than a repeat MRI.

10-14-11 MD., UR non certification for repeat MRI right lower leg, non joint calf area. The patient presently complains of right calf pain with inability to ascend/descend stairs and aggravated by walking. On physical examination dated 10/05/11, there is tenderness on the right mid-calf deep in the area of the soleus versus the gastrocnemius. No swelling is noted. This is an appeal of the request for repeat MRI of the right lower leg, non joint calf area. However, the records submitted still did not include objective documentation that conservative measures for pain management and intervention such as medication use had been done and exhausted to address the patient's signs and symptoms. While it was noted that the patient underwent previous Physical Therapy, serial PT progress reports or latest comprehensive PT evaluation stating the patient's functional improvement/non-improvement and lack of pain relief was not submitted for review, Hence, the necessity of the above request cannot be established at this time. Determination: This request is not certified.

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

The request for a repeat MRI of the right lower leg is not medically indicated. Prior MRI did not reveal objective pathology. Clinical exam by Dr. has noted questionable palpable defect in the muscle belly of the calf with localized tenderness. There was no tear of the Achilles tendon.

Even if another MRI was performed on the calf and muscle changes from an old tear were seen, this would not change any medical care to be provided. This would not result in a surgical repair. Therefore, the request for repeat MRI right lower leg, non joint calf area 73721 is not reasonable or medically necessary.

ODG-TWC, last update 11-2-11 Occupational Disorders of the Knee and Leg - 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)