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DATE OF REVIEW: October 31, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI right knee without contrast

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:

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Diagnostics (05/12/10)
- Office visits (03/02/11 – 07/27/11)
- Utilization reviews (07/19/11 – 08/05/11)

- Office visits (03/10/10 – 08/15/11)
- Diagnostics (05/12/10)
- Operative note (10/26/10)
- Review (05/12/11)
- Therapy (05/14/10 – 02/28/11)
- Utilization reviews (07/19/11 – 08/05/11)

TDI:

- Utilization reviews (07/19/11 – 08/05/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injury to his knee on xx/xx/xx.

2010: The patient was initially evaluated by M.D., an orthopedic surgeon, for pain and tenderness in both knees with occasional mechanical symptomatology, buckling, locking and giving way. History was positive for low back surgery. Examination revealed varus angulation of both knees and plano valgus deformity of the foot with loss of arch height and inversion of the heel; lateral tilt and lateral wink of the kneecap; crepitation of the patellofemoral joint on both sides. X-rays of the knee revealed some lateral tilt and lateral winking of the kneecaps bilaterally. Dr. diagnosed early degenerative type changes of the patellofemoral joint with sclerosis and osteophyte formation, some narrowing of the joint space laterally, contusion of the knee joint with chondromalacia of the patella as rated by malalignment of the knee, overuse and a plano valgus deformity of the foot. Dr. prescribed a Flector patch, placed the patient in an orthotic with a ¼-inch heel lift to realign his lower extremities and released him to regular-type activities. On follow-up, Dr. recommended changing orthotics from a lateral wedge to a medial wedge.

Magnetic resonance imaging (MRI) of the right knee revealed tear at the body of the medial meniscus, mild cartilage loss of the patellofemoral compartment and the weightbearing surface of the medial compartment, minimal joint effusion, grade I medial collateral ligament (MCL) sprain pattern and mild insertional quadriceps tendinosis.

From May through June, the patient attended 11 sessions of therapy.

On October 26, 2010, Dr. performed right knee arthroscopic partial medial meniscectomy and plica resection of the infrapatellar and medial patellofemoral compartments.

From November 2010, through January 2011, the patient attended 19 sessions of physical therapy (PT) and reported significant improvement. Dr. noted improvement in quadriceps strength and power and little effusion and swelling of the knee joint. X-rays revealed some soft tissue swelling but no collapse of the medial aspect of the knee joint.

2011: In January, Dr. evaluated the patient for some discomfort along the medial aspect of the knee joint. The patient had returned to regular activities and had completed therapy. Examination revealed congenital varus stance to his knee with symmetrical alignment. Dr. assessed some residual pain and tenderness along the medial and lateral aspects of knee joint of arthritic type in nature or inflammatory type in nature. Dr. recommended changing the thrust of lower extremities by changing and modifying orthotic from a medial wedge to a lateral wedge and continuing some sort of anti-inflammatory and Flector patch.

From January through February, the patient attended nine sessions of therapy and was discharged.

In March, Dr. noted that the lateral wedge of his medial compartment had antagonized the pain and tenderness in the patellofemoral joint. The patient complained of arthritic-type symptoms in his knee limiting while running and doing activities of that nature. X-rays showed some posttraumatic-type changes of the patellofemoral joint and narrowing of the medial compartment of the knee joint. Dr. assessed some compression and degeneration of the patellofemoral

joint and varus stance with early chondromalacia. He recommended continuing symptomatic treatment including medication, bracing, taping, and cream rubs. He also recommended arthroplasty of the knee joint if the patient's symptomatology failed to resolve with progression of the arthritis.

On May 12, 2011, M.D., a designated doctor, assessed clinical maximum medical improvement (MMI) with 1% whole person impairment (WPI) rating.

On June 29, 2011, Dr. evaluated the patient for ongoing pain and tenderness in the knee and in the medial joint line, medial patellofemoral joint. The patient had improved with arthroscopic evaluation but complained of pain and tenderness in the knee joint and reported diminished strength and power. X-rays of the knee joint revealed bilateral degenerative-type changes of the patellofemoral joint with some sclerosis and osteophyte formation. Dr. recommended continuing symptomatic treatment and ordered a repeat MRI of the knee joint.

Per utilization review dated July 19, 2011, the request for repeat MRI of the right knee was denied with the following rationale: *"The patient most recently was seen on June 29, 2011. He believes he has improved since surgery but still has pain and tenderness in the knee joint. He is noted to have gained all range of motion in the knee. Physical examination showed no effusion or swelling of the knee. There was no quadriceps atrophy. The patient complains of pain in the medial patellofemoral joint and the medial joint line. McMurray's was negative. The patient had full extension and flexion. There was no evidence of instability. He can dorsiflex and plantar flex his foot well. Sensation and circulation was intact. There was no calf pain, tenderness, lymphedema, swelling, alteration of gait pattern or other abnormality noted. Radiographs were repeated of the patient's knee joint on this date with no evidence of fracture, dislocation or other abnormality. Based on the clinical information provided, noting that physical examination was unremarkable with subjective complaints of knee pain, and noting unremarkable x-rays of the knee joint, medical necessity is not established for repeat MRI of the right knee."*

On July 27, 2011, Dr. evaluated the patient for recurrence of pain and tenderness on the medial aspect of the knee joint with some mechanical symptoms. The patient reported some swelling in the medial aspect of his knee joint and little click in the area. Examination showed little effusion and little induration and swelling of the tissues medially and point tenderness on the posterior medial aspect of the knee joint with positive McMurray's with slight click along the medial joint line and some alteration of the gait pattern. Dr. opined that due to recurrence of the patient's present symptomatology and persisting pain and tenderness along the medial aspect of the knee joint, question of McMurray's, swelling and a little click in that area to rule out a re-tear or further fragmentation of the medial meniscus, MRI of the knee joint was necessary.

On August 5, 2011, appeal for the repeat MRI of the right knee was denied with the following rationale: *"The available medical records indicate the claimant is status post surgery and serial records indicate he has residuals which appear unchanged over last several months. There is no indication that the claimant has sustained a new injury. Records do not indicate the claimant has had a trial of conservative treatment in the interval period between previous surgery and this*

request. In the absence of more detailed clinical information the request does not appear substantiated at this time.”

On August 15, 2011, Dr. evaluated the patient for persistent pain and tenderness in the knee joint with mechanical symptomatology at times of buckling, locking and giving way. He opined that all treatment modalities had failed to resolve his symptomatology. Examination was suggestive of McMurray’s, occasional symptoms where his knee wanted to go out on him, little effusion, induration and swelling of the tissues medially and point tenderness on the posterior medial aspect of the knee joint. There might be positive McMurray’s with slight click along the medial joint and alteration of gait pattern. Dr. recommended MRI of the knee joint to rule out re-tear or further fragmentation of the medial meniscus.

On September 23, 2011, the request for repeat MRI of the right knee was withdrawn.

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

On reviewing the documentation, the request has been withdrawn. The records support that the claimant has had increased pain on the medial aspect of the knee joint with positive McMurray’s suggestive of a re-tear of the medial meniscus. The operative note supports that the articular surface of the femur and tibia at the time of the arthroscopy were normal without degenerative changes. According to ODG guidelines indications for imaging for a knee would be mechanical symptoms and/or reassess a repair and/or prior meniscal surgery.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**