

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
12001 NORTH CENTRAL EXPRESSWAY
SUITE 800
DALLAS, TEXAS 75243
(214) 750-6110
FAX (214) 750-5825

Notice of Independent Review Decision

DATE OF REVIEW: August 26, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI of the Left Knee. CPT Code: 73721.

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

FAMILY PRACTICE
PRACTICE OF OCCUPATIONAL 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the URA/Carrier include:

- Official Disability Guidelines, 2008
- 03/26/09, 04/28/09, 05/27/09, 07/02/09
- M.D., 04/11/11
- 07/11/11
- 08/09/11

Medical records from the Provider include:

- M.D., 06/13/07, 08/09/07, 04/11/11
- Progress Notes, 06/13/07, 08/09/07, 04/11/11

PATIENT CLINICAL HISTORY:

The area of injury described is to the left knee and abdomen. The date of injury is xx/xx/xxxx. The treating physician is M.D.

I have medical records on June 13, 2007. The patient was "lifting a box; she said it was much heavier than it supposed to be." She reported that her "shoulder was thrown out of socket," her "neck tore," and her "back tore." She also reported that she "blew out her knee." In the medical records it states that she was able to reduce the shoulder herself without aid. It is noted that following the injury she saw several physicians for pain management, but never had surgery. The diagnosis was dystonia. It is noted that she did undergo rhizotomies by Dr. and was under the treatment of Dr. The additional diagnosis included migraine headaches and fibromyalgia. The patient's medications at the time of consultation included Tizanidine 4 mg, two tablets twice a day; Paxil 20 mg, twice a day; Valium 10 mg at bedtime; Frova 2.5 mg, as needed; Celebrex 200 mg, twice a day; Topamax 100 mg, daily; Avinza 60 mg; Hydrocodone 10 mg, four times a day; and Cymbalta 60 mg. M.D., performed this initial consultation. His assessment was chronic pain. There is nothing more specific. Dr. offered the patient a pain management referral.

There is a follow-up visit with Dr. on August 9, 2007. His physical examination does not corroborate any specific abnormalities other than chronic pain in the neck, low back, and headache. It is reported that she has episodes of near-syncope after shouting.

I have additional medical records. This is a follow-up visit on March 26, 2009, for low back pain and left shoulder pain. The patient's pain was noted to be stable, 5 at its best and 8 at its worst. There was no abnormality noted in the cervical spine on physical examination. There was tenderness of the cervical musculature. There was tenderness of the lumbar musculature. There was decreased lumbar range of motion. There were trigger points in the trapezius. There were trigger points in the rhomboids, paravertebrals, supraspinatus, and infraspinatus. There were multiple areas of trigger points. The assessment was thoracic and lumbar radiculopathy; spondylosis with myelopathy, lumbosacral; degenerative disc disease, lumbar; osteoarthritis; muscle spasm, shoulder region; and pain back. The patient was continued on Avinza, two every 12; Zanaflex 8 mg, q6hr; and Lyrica 200 mg, three times a day. The recommendation was for a CT of the lumbar spine. It is noted the patient could not tolerate MRI. This is reported by M.D.

There is a follow-up visit on April 28, 2009. There was no change in the patient's physical examination. There was no change in her diagnosis. The record states, "She does not have normal sensation. Motor examination reveals abnormalities." These were not quantitated in the record. The patient was continued on her medications.

Review of a CT scan on follow-up visit of May 27, 2009, revealed facet arthropathy at L3-4 through L5-S1 and degenerative disc disease at L5-S1. Avinza and Cymbalta were continued. An MRI of the brain, cervical spine, and lumbar spine were ordered for diagnosis of dizziness, cervicalgia, and lumbosacral neuritis.

There is a follow-up visit with Dr. on April 11, 2011. There was crepitus seen in the left knee. There was mild swelling. The left shoulder was elevated higher than the right. The assessment was dystonia, chronic shoulder pain, and worsening in the left knee, but no more specific diagnosis or pathology offered. However, she did wish to be disabled. To clarify, she wished to apply for disability. Dr. referred the patient to Dr. for her knee problem.

The medical records are corroborated on an adverse determination peer review. This is reported by D.O. It is noted the patient had undergone three arthroscopic left knee surgeries from April 11, 1994,

March 8, 1995, and April 25, 1996. The recommendation was for non-certification as it did not meet the ODG criteria for an MRI.

I have no further documentation.

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

I am asked if the request for an MRI of the left knee is reasonable and necessary. I do not have corroboration of medical necessity for a repeat MRI, according to the ODG. There is a complete paucity of any pertinent physical findings on the assessment by the treating physician to corroborate the necessity for an MRI. The only findings were swelling of the left knee, not hot, with crepitus. This would appear to be of a chronic and degenerative nature. There is no notation of any acute changes which would corroborate medical necessity. Therefore, I would have to uphold the previous determination of non-necessity.

In the ODG recommendations for MRI imaging of the knee, all of them include the caveat/suspicion for internal derangement. There is nothing in the medical documentation I have that corroborates evidence of internal derangement. There is no evidence or notation of ligamentous laxity, abnormality of patellar tracking, misalignment, instability, locking or giving out. There were none of the factors which are usually consistent with internal derangement. As such, there does not appear to have been an interval change in the patient's clinical status to corroborate medical necessity.

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)