



Notice of Independent Review Decision

June 13, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MR Arthrogram Right Knee

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

American Board of Orthopaedic Surgery

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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- 10-6-10 MRI of the right knee.
- 5-11-11 Surgery performed by Dr..
- 5-25-11 Venous Doppler right lower extremity.
- 10-6-11 MD., office visits on 10-14-10, 12-2-10, 1-20-11, 2-24-11, 4-4-11, 5-24-11, 10-6-11, 11-28-11, and 4-17-12.
- 12-6-12 UR performed by MD.
- 12-20-11 UR.

PATIENT CLINICAL HISTORY [SUMMARY]:

10-6-10 MRI of the right knee shows complete ACL tear. Severe bone contusion of the medial femoral condyle. Tear of the fibular collateral ligament. There appears to be an avulsed fibular collateral ligament off its lateral femoral condyle origin. There is at least a sprained popliteus tendon. The biceps femoris tendon and the iliotibial band are intact. No discrete meniscal tears.

5-11-11 Surgery performed by Dr.: Examination under anesthesia, diagnostic right knee arthroscopy, partial medial meniscectomy, extensive debridement intercondylar notch and resection of torn anterior cruciate ligament remnant. Anteromedial/anterolateral compartment synovectomy and partial fat pad excision. ACL reconstruction, intraarticular anesthetic injection. Complex multilayer closure.

5-25-11 Venous Doppler right lower extremity was unremarkable.

10-6-11 MD., the claimant is status post right ACL reconstruction on 05/09/11. She is having some difficulties. She was doing fairly well up until 09/01/11 and on that day, she was at physical therapy and they actually had her bouncing on a tramp. She felt a sudden onset of right knee pain and felt like it wanted to buckle and give out and developed swelling. Since that time, she has had intermittent potassium knee effusions and continues to have a feeling of instability and has also lost motion. She cannot fully extend actively in the terminal 8-10 degrees and passively is quite difficult as well. No distal swelling. No dysesthesias. On exam, compared to the left knee, the right knee definitely now has an increased laxity. This is definitely not where he left her at the time of surgery. She has at least 5 mm or perhaps even up to 7 mm of anterior translation on drawer and Lachman's testing, but the endpoint still is fairly firm. There is a mild boggy synovitis effusion. Portals are all well healed. There is no evidence of infection. She definitely does have difficulty at the terminal active extension. Negative Homans. NVID. Antalgic

gait. Assessment: New injury on 09/01/11-possible graft stretching or disruption. Plan: He was concerned she was already doing the plyometric loading activities back earlier in her rehabilitation course. It looks like she has already exceeded her rehabilitation allotment per OBG. This is not his typical routine, and he was not sure why the therapist was proceeding with these activities. The first two months are just getting range of motion and strength back and smooth-level surface walking only. Months three and four after surgery are meant to be time for the patient to be working on a home-exercise program without formal therapy. Month five is when terminal rehabilitation starts to work on the plyometric transitioning eventually into full activities such as running. She definitely has deficits today. The therapist did not follow his routine protocol, and he did not think this should be held against the patient. He felt she definitely needs feedback in the terminal rehabilitation, and he was hoping that whatever happened to the graft to cause the increased laxity can be overcome by focused hamstring strengthening. He will inject the joint today to knock down any residual inflammation. If she has not much improved in the next six weeks, he will need to get an MR arthrogram.

11-28-11 MD., the claimant reports right knee felt much, much better following a steroid injection. She still feels like it is achy, sore, and sometimes it feels weak. She was never afforded anymore physical therapy per the carrier. The right knee looks better today. It is not swollen. It has good range of motion and maybe a little bit of laxity on drawer and Lachman testing. It is a little bit difficult to assess as she guards fairly heavily. The posterolateral corner remains sore but negative dial test. No distal swelling. Negative Humans. Antalgic gait. X-rays today were fairly unremarkable. Hardware is intact. No evidence of tunnel widening or other complication. Plan: He recommended that they get an MR arthrogram of the knee to confirm there is no substantial residual deficit and then they can perhaps beseech the carrier for more rehabilitation. He felt right now this is mostly a functional issue, but we need to make sure the graft is intact. Also we need to get a good look at that posterolateral corner again.

12-6-12 UR performed by MD., notes the claimant has undergone a right knee arthroscopy with partial medial meniscectomy and debridement, however, the operative report is not included for review. The patient has also received approximately 24 physical therapy sessions, and a steroid injection. The most recent physical examination noted the patient to have a much improved pain level and good range of motion to her right knee. The guidelines recommend an MR arthrogram for meniscal repair and meniscal resection of more than 25%. All patients with meniscal repair required MR arthrography. Patients with less than 25% meniscal resection do not need MR arthrography. There is no clinical documentation submitted revealing the patient was in need of meniscal repair. The patient's range of motion is noted to be within normal limits, and pain to be managed. As such, the request is non-certified.

UR notes the claimant had a fall from a ladder with injury to the right knee including an ACL tear and also injury to the fibular collateral ligament. She had operative reconstruction of the ACL on 5-11-11 and then had difficulty getting her

full range of motion back. She apparently had an incident in therapy with a change in her knee stability in the early September 2011 time frame. She was noted to have increased laxity after that incident but Dr. has reported that she did have improvement in the swelling of the right knee after the steroid injection. Dr. noted that the patient was guarding significantly which compromised a full assessment of the knee but that he did not consider her to have a positive dial test but that there was some increased laxity. The operative report was forwarded and noted only that the medial meniscus had a flap tear. Thus the request for the MR Arthrogram would not meet strict ODG criteria. Further validation is needed.

4-17-12 MD., the claimant returns today after a long absence. She states her right knee has been bothering her substantially. She had an ACL reconstruction in May 2011 and feels like the knee is catching and popping. She has had no interval injury. Sometimes, the knee feels unstable to her. She did not receive her terminal rehabilitation. The right knee was examined and found to have good extension against resistance. Deep knee flexion increased posteromedial tenderness, but there was just an equivocal McMurray's. There did not appear to be substantial laxity of the ACL, and there is some diffuse tenderness in the joint. No distal swelling. Assessment: Right knee internal derangement, status post anterior cruciate ligament repair, synovitis. Plan: To rule out an osteochondral lesion primarily but also because of some mechanical symptoms. He needed to assess the menisci again with MR arthrogram and routine x-rays. He will see her back following those studies.

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

Based on the records provided, the claimant was making good post op progress with a change in symptoms and exam findings. Claimant has also failed to improve with knee complaints. MR arthrogram would help guide which way to proceed with further treatment. Therefore, the request for MR arthrogram would be reasonable and medically necessary.

ODG last update 5-9-12 Knee MRI Arthrogram: Recommended for meniscal repair and meniscal resection of more than 25%. All patients with meniscal repair required MR arthrography. All patients with meniscal resection of more than 25%, who did not have severe degenerative arthrosis, chondral injuries, or avascular necrosis required MR arthrography. Patients with less than 25% meniscal resection did not need MR arthrography. (Magee, 2003)

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)