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Notice of Independent Review Decision

December 24, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI cervical spine (72141)

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

Board Certified Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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:

TDI:

- Utilization Reviews (10/30/12, 11/15/12)

Coventry Healthcare Workers Compensation Inc.:

- Office visits (01/30/12 – 11/01/12)

- Diagnostic (09/05/12)
- Utilization Reviews (10/30/12, 11/15/12)

M.D.:

- Office visits (08/23/11 - 11/28/12)
- Diagnostic (09/08/11)
- Therapy (09/28/11 – 11/12/12)
- Procedure (11/02/11, 04/24/12, 07/20/12)
- Review (10/15/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx, when he fell 16 to 20 feet sustaining injuries to his neck, low back and left knee.

On August 23, 2011, M.D., evaluated the patient for complaints of head laceration and sharp pain in his neck, right elbow and shattered left kneecap. The report is illegible.

On August 24, 2011, M.D., evaluated the patient for a left patellar fracture. He recommended conservative treatment with a knee immobilizer and weightbearing as tolerated with limited use of the leg.

On September 8, 2011, magnetic resonance imaging (MRI) of the cervical spine showed loss of disc signal with 1-mm disc bulges at the C3-C4, C4-C5, C5-C6 and C6-C7 levels. The anterior cerebrospinal fluid (CSF) space was partially effaced. The spinal canal remained well in excess of a centimeter. There was straightening of the cervical spine.

From September 8, 2011, through November 21, 2011, the patient attended five sessions of physical therapy (PT) consisting of heat/ice, electrical stimulation, ultrasound and manual therapy.

On November 2, 2011, Dr. Siller performed left knee arthroscopy with partial medial meniscectomy and chondroplasty of the patella. Postoperatively, he recommended PT.

From November 22, 2011, through February 15, 2012, the patient attended 20 sessions of PT consisting of ultrasound, manual therapy and therapeutic exercises.

On January 30, 2012, Dr. noted that the patient was attending physical therapy (PT). The patient had knee pain anteriorly, mainly in the medial and lateral sides of patella. He also had back pain for which he was treated by another physician and had undergone some recent injections as well. Examination of the knee showed no effusion and good range of motion (ROM). X-rays of the left knee revealed healing patellar fracture. There was still a fracture line visible possibly

related to previous bipartite patella. Dr. recommended MRI of the left knee as the patient continued to have pain in the patellofemoral joint region with some visible lines on x-rays and because of some persistent weakness on exam. He also recommended continuing PT, using an elastic knee brace and obtaining pain medications from his back physician.

On February 27, 2012, Dr. noted that the patient had persistent pain in the patellofemoral joint and around the patellar region. He was still getting some mechanical symptoms and giving way related to some weakness. Examination showed a very mild effusion, good ROM, stable ligaments and minimal tenderness of the medial joint line. The patient had a previous partial meniscectomy. X-rays of the left knee revealed a vertical fracture line running to the lateral aspect of the patella visible on the sunrise view consistent with a delayed or non-union. Dr. assessed non-union of left patellar fracture and status post knee scope with partial meniscectomy and recommended obtaining a computerized tomography (CT) scan instead of an MRI. He opined that the patient might need internal fixation with bone grafting and a bone scan.

On March 22, 2012, M.D., noted that the patient had not had a full course of PT. The patient continued to have pain in his back with radiation down his legs, left greater than right. ROM was limited and there was 4/5 weakness in the left tibialis anterior and extensor hallucis longus. Dr. recommended further therapy.

On April 2, 2012, Dr noted that the patient had low back pain and popping with lumbar spine ROM especially in flexion. Dr recommended PT for strengthening.

On April 3, 2012, Dr. noted that the patient had undergone CT scan that confirmed the vertical fracture through the patella representing a non-union from the previous patella fracture. The bone scan also showed moderately increased activity of the patella consistent with the non-union as well. The patient was complaining of a pain as well as difficulty bending, squatting and kneeling. He was unable to go up or downstairs in a routine fashion. He had been through extensive PT and had failed conservative treatment that included multiple medications as well as therapy in the past. He was seen by Dr. for a work-related back injury. Examination of the left knee showed mild swelling, tenderness to deep flexion, tenderness and pain to resisted quadriceps contracture and pain with any type of lunge or step-up on to a small stepping stool. He had very little localized pain medially where he had a right complex medial meniscal tear treated previously. Dr. assessed non-union vertical fracture left patella as seen on CT scan and with some moderate activity on bone scan as well. He recommended internal fixation of the patella.

From April 9, 2012, through April 20, 2012, the patient attended seven session of PT consisting of therapeutic exercises.

On April 24, 2012, Dr. performed open reduction internal fixation (ORIF) of the left patellar fracture using three 4.0-mm cannulated screws and iliac crest bone grafting to the left patella.

Postoperatively, on May 3, 2012, Dr. noted that the patient was doing well. The incisions looked good both at the pelvic area and the patella. X-rays of the knee revealed three screws to be in excellent position with well alignment of the fracture without signs of loosening. Dr. placed the patient in a postoperative hinged knee brace and recommended PT and full weightbearing.

On May 17, 2012, Dr. noted that the patient was about one month from his internal fixation of the patellar fracture. The pelvic and knee incisions were doing well without signs of infection. The patient's ROM was about 0 to 95 degrees. He was still weak in the quadriceps and was getting some hyperextension in the knee from time to time. He was attending therapy. He seemed to be in moderate pain with movements. He was still seeing Dr. and Dr. regarding his neck and lower back. X-rays of the knee revealed patellar fracture to be in excellent position and appearing to be healing especially on the sunrise view with no signs of hardware loosening or any other problem arising. Dr. unlocked the brace from 0 to 90 degrees and recommended active ROM, SLR and some isometric exercises and continuing full weightbearing.

On May 30, 2012, Dr noted that the patient had completed a six-week course of active PT and had received an epidural steroid injection (ESI). The patient continued to have pain in his back with radiation down his legs, left greater than the right. Examination showed 40 degrees forward flexion, pain with SLR on the left at 30 degrees, but no pain on the right side. The patient had grade 4/5 weakness in the left tibialis anterior and extensor hallucis longus (EHL). The left ankle reflex was absent. Dr. recommended resubmitting for surgery.

On May 30, 2012, Dr. noted that the patient had neck, back and left leg pain. He prescribed Norco for pain.

On June 7, 2012, Dr. noted that the patient was seven weeks from the internal fixation of the patellar fracture non-union. He had been doing quite a bit of home exercises. The patient had noticed some swelling and had increased pain around the patella with activity. He continued to use the hinged knee brace at 0 to 90 degrees. Examination of the left knee showed mild-to-moderate swelling, well-centered patella and healed incision. The patient was able to do SLR and could flex to 95 or 100 degrees. X-rays of the left knee showed healing patellar fracture, intact three screws and no signs of loosening. Dr. recommended continuing walking, use of brace, SLR and active ROM.

On July 12, 2012, Dr. noted that the patient was doing quite well. He was scheduled for a lumbar surgery in another week to ten days. His ROM had improved. His strength was improving but it still gave out of the knee from time to time. X-rays of the left knee showed healing patella fracture with intact hardware

between the screws. He was still proceeding with his lumbar surgery and follow-up in two months.

On July 20, 2012, Dr. performed decompression laminectomy at L4, L5 and S1 and bilateral foraminotomies at L4-L5 and L5-S1.

Postoperatively, the patient was seen at Hospital by, M.D., for the pain at the surgical incision site with some trouble ambulating secondary to the pain. Dr. noted that the patient had failed outpatient medical therapy and had undergone decompression of L4-S1 on July 20, 2012. Dr. assessed back pain secondary to an on-the-job injury, radiculopathy secondary to the on-the-job injury and gait dysfunction. He prescribed Norco and recommended morphine patient controlled analgesia (PCA), ambulation with assistance, deep breathing exercises and a SCD boots.

On July 31, 2012, Dr. noted that the patient was doing well and he had his leg pain improved. Examination showed well-healed incision. Dr. placed the patient on off work.

On August 16, 2012, Dr. noted that the patient was having pain in the midthoracic spine. Examination showed pain on palpation of one area in the midline. Dr. recommended starting therapy for both the thoracic and lumbar spine.

On September 5, 2012, Dr. evaluated the patient for some increased symptoms in his neck and mid back. The neck pain had been associated with radiating pain down the arms, left greater than right. The patient also had some numbness in his left hand. Examination of the neck showed tenderness in the trapezius on the right and left side. The patient had decreased sensation in the left C6 dermatome. The low back examination showed well-healed incision, flexion to 30 degrees only and some back pain with SLR. Dr. opined that the patient was a good candidate for therapy to address his neck, mid back and low back.

On September 6, 2012, Dr. noted that the patient had a bit of weakness in the left knee. He had been trying to do exercises at home. He was attending therapy for his lumbar spine and cervical spine and had undergone lumbar spine surgery. Examination of the left knee showed some chronic enlargement of the patella from the previous fracture and surgeries, but appeared to be quite stable. The patient had almost full extension. He could flex to about 100 degrees. X-rays of the left knee showed three screws and intact patella without signs of loosening. The patella appeared to be healing further. Dr. recommended continuing home exercises for left knee and follow-up in two months.

From September 17, 2012, through November 12, 2012, the patient attended 18 sessions of PT consisting of manual therapy and therapeutic exercises.

On October 4, 2012, D.C., opined that the patient had made progress with ROM and was slowly progressing in overall strength. The therapy moderately helped his cervical spine and somewhat to his left knee as well.

Per Claim File Analysis dated October 15, 2012, following treatment history was noted: *Following the injury, the patient was seen at Medical Center where he underwent multiple diagnostic studies. X-rays of the left knee showed multiple minimally displaced fractures of patella with small left knee joint effusion. X-rays of the pelvis and CT scan of the head was unremarkable. CT scan of the cervical spine showed spina bifida occulta.*

On August 4, 2011, the patient was evaluated at by, M.D., who assessed a minimally displaced right patella fracture, after a fall from approximately 20 feet the previous day. It was also noted that the patient had sustained a laceration to the top of his head. He was seen at Angleton emergency room (ER) and was placed in knee immobilizer. Treatment plan was an orthopedic consultation and continued use of the knee immobilizer.

On August 4, 2011, x-rays of the left knee showed a comminuted fracture to the patella, significant prepatellar soft tissue thickening and a large suprapatellar joint effusion/lipohemarthrosis.

On August 31, 2011, CT scan of the brain was unremarkable.

On September 8, 2011, MRI of the lumbar spine showed the following findings: (1) At L4-L5, moderately advanced loss of disc height and signal with an approximately 3-mm disc bulge. The anterior margin of the thecal sac was contacted and partially effaced. There was mild-to-moderate compromise of the left and right lateral recesses with contact of the L5 nerve roots. (2) At L5-S1, moderately advanced loss of disc signal with a 4 to 5-mm central disc protrusion/herniation. Disc material extended slightly above, as well as below the disc level. There was compromise of the left and right lateral recesses with contact of the S1 nerve root sheaths, as well as compromise of the neural foramina bilaterally with compression of the exiting L5 root ganglia.

On September 15, 2011, MRI of the left knee showed a complex fracture involving the patella. There was moderately large amount of edema consistent with acute or subacute fracture and moderately large oblique tear involving the posterior horn of the medial meniscus extending to the inferior articular margin. There was patchy subchondral edema involving the tibial aspect of the joint space. There was moderately large amount of marrow edema involving the anterior articular margin in the both lateral femoral condyle as well as lateral tibial plateau. This was likely bony contusion in the clinical setting.

On September 7, 2011, Dr. noted that the patient was wearing two knee immobilizers around the knee and was using crutches. The patient reported that

the knee and the leg wanted to give out when he put weight on it despite having two immobilizers on the left. Dr. recommended MRI of the left knee and PT.

On September 21, 2011, the patient was seen by Dr. for complaints of neck and low back pain. He opined that the patient was an excellent candidate for a lumbar epidural steroid injection (ESI).

On October 4, 2011, the patient was evaluated by M.D., for pain management. He noted that the patient experienced anxiety attacks lately. History was positive for smoking marijuana at least three to four times in a month, with the last time four days ago. The patient was utilizing Lortab and ibuprofen. Dr. assessed lumbosacral spondylosis and degenerative disc disease (DDD), lumbar radiculopathy and lumbar facet joint syndrome and ordered electrodiagnostic studies of the lower extremities and left lumbar ESIs at L4, L5, and S1.

On October 7, 2011, Dr. reported that the MRI of the knee showed a moderately large oblique tear of the posterior horn of the medial meniscus and recommended surgical intervention.

On November 9, 2011, x-rays of the chest showed spina bifida occulta of T1 and T3.

Dr. saw the patient for postop visits approximately every two weeks through December 1, 2011. He obtained x-rays which showed healing comminuted patellofemoral fracture without further separation. Dr. recommended weaning off the Lortab, continuing therapy and no work activities.

On December 13, 2011, the patient was seen by M.D., for pain in the low back with radiation to the posterior lateral aspect of both legs. He prescribed Lortab and Xanax and recommended a bilateral transforaminal ESI at L5 and S1.

On January 6, 2012, the patient underwent bilateral lumbar transforaminal ESIs at L5 and S1 by Dr..

On March 21, 2012, CT scan of the left knee showed significant disuse osteopenia creating a permeative pattern and nonunion of a vertical fracture of the lateral patella.

Total body bone scan showed posttraumatic change to the left patella with probable changes in gait, related degenerative changes in the left knee and periodontal disease of the right mandible.

On October 15, 2012, M.D., performed a designated doctor evaluation (DDE) and opined that the patient was not at maximum medical improvement (MMI). The patient still had six to eight weeks of PT remaining to address his neck, mid back and low back.

On October 15, 2012, electromyography/nerve conduction velocity (EMG/NCV) of the upper extremities showed left median nerve entrapment at the wrist, moderate to mild, decreased right ulnar amplitude, bilateral peroneal nerve abnormalities, left C6 nerve root irritation.

On October 23, 2012, the patient underwent a functional capacity evaluation (FCE) and was allowed to return to work with restrictions.

From October 25, 2012, through October 30, 2012, the patient was seen at Island Health Center. The reports are illegible.

Per the utilization review dated October 30, 2012, the request for a cervical MRI was denied by M.D., with the following rationale: *“The patient is a male who fell 16 to 20 feet sustaining injuries to the neck, low back and left knee. Per office note dated xx/xx/xx, the patient was noted to have completed a six-week course of active physical therapy and received an epidural steroid injection. He continues to have low back pain radiating down his legs left greater than right. There is no examination of the cervical spine or upper extremities, and no documentation of treatment to date for the cervical spine. No plain radiographs of the cervical spine were provided. Based on the clinical information provided, the request for cervical MRI is not recommended as medically necessary. Addendum: I discussed the case with Dr. on October 30, 2012, at 12:44 PM CST. The MRI was last done year ago. Since then, he has worsening pain, now with increasing neurological changes as numbness and tingling. Dr. is getting ready to refer the patient to a surgeon. However, there still is no detailed physical examination of the cervical spine or upper extremities, and no history of treatment to date for the cervical spine. As such, I do not recommend the MRI.”*

On November 1, 2012, Dr. evaluated the patient for ongoing pain in the left patella and feeling of weakness and giving out. The patient reported that his left knee made crunching sounds. He was utilizing ibuprofen, muscle relaxers and hydrocodone. Examination of the left knee showed well-healed incision, well-aligned patella and mild crepitation. X-rays of the left knee showed internal fixation of the patella and healing fracture. Dr. assessed closed fracture of the left patella; recommended continuing ibuprofen, hydrocodone and muscle relaxers and PT and full weightbearing. He ordered CT scan to assess healing.

On November 14, 2012, Dr. noted that the patient had continued neck and left knee complaints. The patient reported popping of neck and cracking whenever he turned to the right and left sides. He also had pain in his left knee whenever he stood for long periods of time. Examination showed markedly limited and painful ROM of the neck. Examination of the low back showed 30 degrees of flexion. Dr. opined that there was nothing further to offer the patient surgically. He recommended ongoing pain management under Dr. and referral for assessment of his left knee pain.

Per the reconsideration review dated November 15, 2012, the request for cervical MRI was denied with the following rationale: *“This is an appeal for a cervical MRI. The previous request was non-certified due to lack of documentation of an examination of the cervical spine or upper extremities, no documentation of treatment to date for the cervical spine, and no plain radiographs of the cervical spine were provided. Updated documentation, as per September 5, 2012, report noted that patient presenting with neck pain that radiates down the arms, left greater than right and numbness in the left hand. The physical examination showed tenderness on the trapezius on the right and left sides, normal strength, and decreased sensation over the left C6 dermatome. The October 14, 2011, report noted decreased sensation in a glove distribution over the upper extremities with normal strength and reflexes. It is noted that the last cervical MRI was done more than one year ago and showed some disc bulging, but no discrete spinal cord or nerve root compression. However, there was still no submission of recent plain radiographs of the cervical spine. There was also no specific documentation regarding prior recent conservative treatment directed to the cervical spine, as the PT reports submitted targeted the lumbar spine. After receiving the MRI report, it was discussed with Dr. that as there were very minimal disc bulges there is not good rationale for a repeat MRI. Hence, the previous non-certification is upheld.”*

Per record from Center dated November 28, 2012, the patient was informed that the second request of the MRI was denied.

Per letter dated December 5, 2012, from Company, there was mutual agreement between Company and Dr. M.D., for Xanax and metaxalone for the patient.

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

Based on the medical records available there is no supporting documentation to fit the criteria of a repeat MRI per ODG. A MRI performed a year ago revealed bulging discs and EMG in October failed to confirm a radiculopathy. In addition, Dr. Esses' evaluation found no evidence of neurologic deficits and he was released from the surgeon. Per ODG: **Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation).**

Therefore, the decision is upheld.

IRO REVIEWER REPORT TEMPLATE -WC

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES