

# Icon Medical Solutions, Inc.

11815 CR 452  
Lindale, TX 75771  
P 903.749.4272  
F 888.663.6614

## Notice of Independent Review Decision

**DATE:** September 16, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Magnetic Resonance (EG, Proton) Imaging, Any Joint of Lower Extremity; Without Contrast Material, Left Knee MRI Arthrogram

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

The reviewer is certified by the American Board of Orthopaedic Surgery with 42 years of experience.

**REVIEW OUTCOME:**

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

Upheld (Agree)

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:**

09/13/11: X-ray Left Knee report interpreted  
11/22/11: Initial Consultation  
12/08/11: MRI Knee W/O Contrast report  
12/16/11: Electrodiagnostic results (only one page submitted; not complete)  
05/08/12, 05/14/12, 05/16/12, 05/21/12, 05/23/12, 05/31/12, 06/12/12, 06/14/12,  
06/18/12, 06/20/12, 06/26/12, 06/29/12, 07/16/12, 07/20/12, 07/24/12, 07/25/12,  
07/27/12, 07/31/12, 08/02/12, 08/07/12, 08/10/12, 08/13/12, 08/14/12, 08/16/12:  
Therapy notes (no facility or therapist name given)  
06/25/12, 08/23/12, 10/04/12, 01/03/13, 05/16/13: Office visit  
07/09/12: Followup clinical Behavioral Health Assessment  
08/23/12: Functional Capacity Evaluation Summary Report  
10/11/12: Preauthorization Request  
11/06/12: Operative Report  
11/20/12: Progress Notes  
11/20/12: Referral Form

01/31/13: Functional Capacity Evaluation Summary Report by PT with Testing  
04/11/13: Office visit  
05/16/13: Referral Form  
05/16/13: Progress Notes  
05/24/13: UR  
06/11/13: Physical Therapy Evaluation  
06/14/13: Preauthorization request  
07/17/13: Chart review  
08/06/13: UR performed  
08/23/13: Letter from  
08/26/13: UR  
08/27/13: Letter

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who injured her low back, left shoulder, and left knee when she slipped and fell in some water while working on xx/xx/xx. She is status post left knee surgery performed on November 6, 2012.

12/08/11: MRI Left Knee without Contrast report. IMPRESSION: Slight asymmetric thinning of the cartilage in the medial knee joint compartment, but it is seen in both medial and lateral compartments. There is subchondral cyst formation central most portion of the lateral tibial plateau. This is degenerative. Meniscal degenerative changes but no focal meniscal tear is seen. Prepatellar subcutaneous edema.

11/06/12: Operative Report. POSTOPERATIVE DIAGNOSIS: Partially torn anterior cruciate ligament and posterior cruciate ligament, partially torn medial and lateral meniscus, complete pre-compartment synovitis and adhesions. PROCEDURE PERFORMED: Left knee diagnostic arthroscopy with anterior cruciate ligament repair using human allograft, posterior cruciate ligament repair using human allograft, partial medial and lateral meniscectomy, complete synovectomy, removal of adhesions, and instillation of platelet rich plasma.

11/20/12: The claimant was evaluated for postop pain and swelling. She underwent a left knee scope on 11/06/12. She had decreased range of motion. She was to continue her medications prn and start early PROM exercises and advance to active postop PT 3 x week for 4-6 weeks.

01/03/13: The claimant was evaluated. On exam, she had full range of motion of the left knee. 3/5 quadriceps strength. Diffuse soft tissue swelling. This was a hand-written note and "release" was written on the form.

04/11/13: The claimant was evaluated. She rated her pain as 3-4/10 in her left knee. It was noted that Naprosyn and Elavil were helpful. The plan was to advance to home exercises and was given a prescription for compound pain cream.

05/16/13: The claimant was evaluated for left knee pain and swelling. She complained of buckling and giving away x 4 episodes. On physical exam of the left knee, she had diffuse soft tissue swelling. Positive McMurray. 3/5 strength. ordered an MR Arthrogram.

05/24/13: UR performed. Clt is status post left knee diagnostic arthroscopy with ACL repair, PCL repair, partial medial and lateral meniscectomy, complete synovectomy, removal of adhesions, and instillation of platelet rich plasma on 11/06/12. There is no documentation of the amount of meniscal resection in the clinical notes. Medical necessity cannot be established at this time so this request will be sent for peer review.

06/11/13: The claimant was evaluated by PT. ASSESSMENT: Left knee/lumbar pain and weakness interfering with functional ADLs. Restrictions in the left tibiofemoral joint and lumbar ROM. Left quadriceps/core and hamstring muscle weakness. Left knee and lumbar instability. PLAN: It is recommended that the examinee participate in active physical rehabilitation services x 3 sessions in order to address the aforementioned pain levels, limitations and impairments. Intervention may include: aquatic exercise, neuromuscular reeducation, gait training, therapeutic activities, therapeutic procedures, and examinee/family education. It is also recommended that the examinee follow-up.

07/17/13: The claimant's chart was reviewed. He noted that she reported left knee discomfort/instability with active range of motion and if she had to kneel, squat, or bend at the knee. She had tried and failed medication, bracing, surgical intervention, and postop physical therapy. noted that she was released back to treating doctor on 01/03/13 with good post-surgical results and returned now with worsening condition. Physical exam findings were noted to be range of motion limited by pain, diffuse soft tissue swelling, medial and lateral joint line tenderness, positive McMurray's, and 3/5 muscle strength. stated that an MRI Arthrogram of the left knee was medically necessary to rule out residual or recurrent meniscal tear/ligamentous damage.

08/06/13: UR performed. RATIONALE: In this case, the percentage of meniscal resection could not be determined with the given information. Medical necessity within these guidelines (ODG Knee/Leg Section) could not be determined after two successful calls over two consecutive days.

08/26/13: UR performed. RATIONALE: According to ODG, MR arthrography is recommended as a postoperative option, to help diagnose a suspected residual or recurrent tear, meniscal repair, or meniscal resection of more than 25%. In this study for all patients who underwent meniscal repair, MR arthrography is required to diagnose a residual or recurrent tear in patients with meniscal resection of more than 25% who do not have severe degenerative arthrosis, avascular necrosis, chondral injuries made of joint fluid that extends into a meniscal or tear in the new are. MR Arthrography is useful in the diagnosis of residual or recurrent tear. Patients with less than 25% meniscal resection did not need MR arthrography. In

this case, the percentage of the meniscal resection from the original surgery cannot be determined. It is unknown if there is any degenerative arthrosis.

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

The previous adverse decisions are upheld. There is no documentation regarding the percentage of the meniscal resection from the original surgery. Per ODG, it is recommended that patients with less than 25% meniscal resection not undergo MR arthrography. Therefore, the claimant does not meet the Official Disability Guidelines. The request for Magnetic Resonance (EG, Proton) Imaging, Any Joint of Lower Extremity; Without Contrast Material, Left Knee MRI Arthrogram is not found to be medically necessary and is not certified.

**ODG:**

MR arthrography	Recommended as a postoperative option to help diagnose a suspected residual or recurrent tear, for meniscal repair or for meniscal resection of more than 25%. In this study, for all patients who underwent meniscal repair, MR arthrography was required to diagnose a residual or recurrent tear. In patients with meniscal resection of more than 25% who did not have severe degenerative arthrosis, avascular necrosis, chondral injuries, native joint fluid that extends into a meniscus, or a tear in a new area, MR arthrography was useful in the diagnosis of residual or recurrent tear. Patients with less than 25% meniscal resection did not need MR arthrography. ( <a href="#">Magee, 2003</a> )
-----------------	--

MRI's (magnetic resonance imaging)	<p><b>Indications for imaging -- MRI (magnetic resonance imaging):</b></p> <ul style="list-style-type: none"> <li>- Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption.</li> <li>- 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.</li> <li>- 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.</li> <li>- 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.</li> <li>- 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).</li> <li>- <i>Repeat MRIs:</i> Post-surgical if need to assess knee cartilage repair tissue.</li> </ul> <p>(<a href="#">Ramappa, 2007</a>) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. (<a href="#">Weissman, 2011</a>)</p>
------------------------------------	--

**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)**