

Vanguard MedReview, Inc.

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Notice of Independent Review Decision

April 14, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Magnetic Resonance Imaging (MRI) of the Right Knee Without Contrast as Outpatient

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

This physician is a licensed chiropractor with over 20 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his knee on xx/xx/xx while at work. When his right foot was stuck in a mud puddle, he twisted his upper body and heard a snapping sound and experienced pain in the right knee.

07/12/2012: Operative Procedure Report. **Preoperative/Postoperative Diagnosis:** Right Knee Internal derangement, Lateral meniscus tear (ICD: 717.9)
Operations: Right knee arthroscopy with partial lateral meniscectomy (CPT 29881).

09/17/2012: Follow up Examination **Subjective:** Today the patient notes on a V.A. scale of 0-10 that his overall pain level goes between a 2 and a 6. He does find again that daily living activities generally aggravate his condition. He does not find that his knee is stabilizing, as a matter of fact, he feels like it is getting a little bit

worse. He does find that elevation, rest, use of ice packs, massage, and prior physical therapy has been helping his recovery. Examination shows the patient has no significant changes in his overall physical parameters. In review of his orthopedic, neurologic, ROM, palpatory findings, and strength show no significant changes. **Plan:** 1. The patient will follow up in 2 weeks. 2. The patient will maintain modified work status for 2 weeks. 3. The patient will be ordered to have status post injection physical therapy according to the ODG. 4. The patient will continue medication management. 5. The patient will be referred for orthopedic review which is now setup for 10/4/2012.

10/22/2012: MRI Right Knee. **Impression:** 1. Lateral meniscal tear with adjacent intrameniscal cyst formation. 2. Proximal tibial osteochondroma. 3. Distal femoral chondroid rest.

01/30/2013: Operative Report. **Postoperative Diagnosis:** Primary lateral meniscus recurrent tear with minimal stiffness. **Operative Procedures/s:** Manipulation under anesthesia followed by right knee arthroscopic lateral meniscectomy, CPT code 29881. ICD 9 is 836.1

02/01/2013: Follow up Orthopaedic Evaluation. **Subjective:** 1/20/13, Medical Center, right knee lateral meniscectomy with manipulation (femoral nerve block for postoperative rehabilitation with CPM) **Objective:** ROM weights now to 88 degrees where his preop was 80 degrees. **Plan:** I have reviewed with him all of the different ways to work on flexion. I emphasized to him that this is so critical that overall benefit of the surgery will be determined by how much he works on flexion. He will be in physical therapy this next week and have his sutures removed on the . I will check his progress in 8 weeks. I have reviewed with him how to gradually wean off the crutches.

02/05/2013: Follow up Examination. **Subjective:** Today he presents postoperatively and his pain level goes between a 3 ½ and a 7. He does feel sore, but also feels like the internal part of his knee has been corrected. The remarkable pain that he was having inside his knee has reduced. Otherwise, medication management, elevation, ice, and his CPM unit with brace will be helpful for him. **Physical Examination:** Examination today shows that the patient has two appropriately healing surgical portal scars anteriorly of the right knee. There is appropriate edema noted at the surgical sites and to the lateral compartment. ROM is restricted secondary to pain. **Plan:** 1. The patient will follow up in two weeks. 2. The patient will maintain no work status for 2 weeks. 3. The patient will continue medication management. 4. has recommended that the patient have a home use CPM and would like the patient to begin postoperative active rehabilitation per ODG.

05/02/2013: Patient Evaluation. **HPI:** The patient reports a VAS score of 7-8. The pain is worse with activity, driving, standing, or walking. Since the original onset of pain he has undergone pain management procedures including knee joint injections 8-9 in the last 7 months. He had good relief for 2 days. Then the pain was back to normal. Surgery as indicated in the history. Diagnostic studies

including MRI and X-Rays; X2 surgeries; physical therapy 7/18-8/18/12 and 3/13-4/04/13, therapy made the pains worse. Narcotic medications patient is taking include Norco 10-325 1 po QID to 5 a day. Additional medications include Ibuprofen 800 mg TID. **Plan:** 1. Aspiration done today. 2. My office will seek authorization for Synvisc (supplemental) injections given the extent of disease noted in the joint as well as the previous short term relief noted with corticosteroid injections. This treatment should allow for better long term relief of symptoms. Will follow treatment with weaning of narcotic medications.

06/21/2013: Follow up Evaluation. **Objective:** He did see who ended up doing some aspiration of the knee. Apparently submitted for Synvisc and this was initially denied. discontinued therapy because of the selling prior to aspiration. **Plan:** 1. The patient is still a candidate for the Synvisc. Aggressive therapy could include a DeRom Home Flexion unit. 2. If they won't allow synovial supplementation, he has failure of the mechanical therapy treatment, then we may not have any other options except to submit for manipulation under anesthesia and anterior synovectomy. This will need to be followed by aggressive CPM beginning from a hyperflexed position as well as chronic pain management.

07/02/2013: Follow up Examination. **Subjective:** Today the patient notes on a V.A. scale of 0-10, that the pain level goes between a 2 ½ and 7. Medication management has been helpful as well as the prior aspiration though his knee has again filled up with fluid and has become stiff and sore. **Physical Examination:** Examination of the knee shows that the patient continues to have ROM with flexion 92 degrees and extension -6 degrees. There is edema noted with the knee with slight effusion. Strength of the right knee is a 4/5, reduced secondary to pain. Palpation, particularly peri patellarly caused marked pain and discomfort. **Plan:** 1. Maintain no work status. 2. Continue Medication management. 3. Continue with individual psychological therapy due to his ongoing psychosocial stressors. 4. Since the patient, who was a candidate for synovex therapy has been denied, the patient would now benefit from the only reasonable course of action which will be a manipulation under anesthesia with an anterior synovectomy. This would be followed by a CPM unit as well as chronic pain management program and physical therapy intervention.

09/11/2013: Operative Report. **Preoperative Diagnosis:** Recurrent ankylosis, right knee. **Postoperative Diagnosis:** 1. Significant anterior and anteromedial compartment synovitis. 2. Recurrent lateral meniscus tear, anterior horn. 3. Chondral debris. **Procedures:** Arthroscopic multi-compartmental synovectomy after MUA 2. Partial Lateral meniscectomy.

10/01/2013: Follow up Evaluation. **Subjective:** The patient is 3 weeks status post manipulation under anesthesia arthroscopic synovectomy. **Objective:** The patient has had a lot of symptoms with weather changes but feels he is better. He is still waiting approval for physical therapy. He is using his CPM at home up to 70 degrees. He has continued to take Hydrocodone as his only medication. **Physical Examination:** The patient's range is 102 degrees but with anterior soreness. Normally he goes to 126. **Plan:** 1. The patient is a candidate for anti-inflammatory

analgesic cream as well as oral anti-inflammatories. This would help him discontinue the narcotic pain medicine. 2. Physical therapy would still be appropriate from a conditioning standpoint but he needs to ambulate as much as possible and work on his ROM 4-6 times a day. With increased endurance and control of inflammatory symptoms, the patient should be able to return to work possibly after he has a work hardening program. 3. I have discussed with the patient the neurogenic feedback on the knee pain and stiffness as he was under anesthesia he had much more flexibility. This means he needs a degree of neuromuscular reeducation. 4. Patient will follow up in approximately one month.

01/06/2014: Follow up Examination. **Subjective:** Today the patient notes on a V.A. scale of 0-10 that the pain level goes between a 2 and a 7 ½ . He continues to have general and gradual improvement with participation in the Chronic Pain Management Program. He feels that his ability to perform daily living activities is increasing and his prospects of return to work post next 10 sessions is looking much better for him. In addition, he has found that use of proper coping skills with home exercise has continued to increase his strength in the right lower extremity and decrease his pain. **Physical Examination:** Right knee shows flexion 108 degrees, moderate pain and -1 degree extension. Today the patient has point tenderness noted medially, laterally, and subpatellarly with the right knee. There is +1 edema noted. Strength of the right knee is a 4+ to a 5-/5, reduced secondary to pain. Gait remains minimally to moderately altered. **Plan:** 1. Patient will follow up in 30 days 2. Patient will maintain no work status for 30 days 3. Patient will continue medication management. 4. Patient will start his next 10 session for Chronic Pain Management Program focusing on increasing his activities with decreased medication management, return to work with DARS, increased ROM to full and increased strength to 5/5.

01/21/2014: Patient Evaluation. **Current Medications:** The patient takes four hydrocodone, Tylenol 10/325 a day, Motrin 800 mg/day, and tizanidine 4 mg/day. **Physical Examination:** The patient has a trace edema in the lower extremities. There is weakness in his right lower extremity associated with walking because of pain. He is negative for clonus and fasciculations. The quadriceps, hamstrings, ankle flexors and extensors, EHL, and toe flexors and extensors are 5/5 on the right and 5/5 on the left. The right thigh is 68.0 cm and the left thigh is 66.5 cm. The right calf is 49.5 cm and the left calf is 48.0. The ankle is 29 cm on the right and 28 on the left. The reflexes are 1 + in the knees and ankles bilaterally. The ballotment of the kneecap is 3+ painful. There is tenderness to palpation of the quadriceps insertion into the tendon. The fat pad and knee on the left inferior aspect of the knee is T2. The patellar tendon and the quadriceps is T3. The right knee is 3_ tender. He is tender along the joint lines, and he is tender at the insertion of the quadriceps and femoris into the superior patella. The knee is mildly swollen globally. Flexion is 85 degrees and extension is zero degrees. The left knee is nontender and nonswollen. Flexion is to 125 degrees and extension is zero degrees. **Impression:** 1. The patient has a right knee sprain and strain. 2. He is status post three surgeries with torn menisci laterally of the right knee. 3. In addition, he has now hypertrophy of the right knee synovium as well. **Plan:** 1. I plan to place a lidocaine patch over the right knee for pain relief as well as start

patient on colchicine 0.6 mg twice a day. In addition, I will be giving him Ansaid 100 mg twice a day. A consideration for a topical Voltaren gel is also to be given. 2. The patient is to continue on his pain medication hydrocodone 10/325 four a day. The Motrin will be discontinued and the tizanidine will be discontinued. 3. The patient will be given consideration for oral steroids in the occasion shall arise. 4. Currently the MRI scan, the Ansaid, and the colchicine with the hydrocodone would be initial steps in treating the chronic synovitis and arthritis that the patient has now developed in his knee.

02/06/2014: Follow Up Evaluation. **HPI:** The patient's pain scale is 7-8/10. A recent evaluation is indicative of a possible recurrent meniscal tear. He still has swelling and tenderness to the right knee. He has difficulty flexing and extending a full range of motion. He has pain with increased activity, and the knee is better with rest and heat. **Physical Examination:** The right knee is globally tender to palpation and mild to moderately swollen. He has 80 degrees of flexion and -20 degrees of extension lag. **Plan:** 1. I plan to place a 5% lidocaine patch over the right knee anteriorly and mid patella to inferior patella. 2. Continue hydrocodone 10/325 four a day and Motrin 800mg. 3. It was noted that 20 minutes after the application of the Lidoderm patch to the right knee, the patient's pain intensity had decreased from 7-8/10 to 3-4/10 and he was able to walk better and felt much better.

02/20/2014: UR. Rational for Denial: At 3:45 p.m. Eastern Standard Time we had a successful peer conversation concerning Mr. who is a male who is injured on xx/xx/xx. It appears he has had three surgeries to his right knee. He stands 5 feet 6 inches tall and weighs 269 pounds. He continues at the time to have chronic pain, swelling, and edema in the right knee. He has been to a chronic pain management program. He has been getting better however he was concerned about the arthritic changes and not being able to have full extension, unable to squat on that leg. He was seen who was concerned about arthritic changes and weakening and grinding with active motion and point tenderness throughout the knee. Based on the guidelines the medical necessity has not been established for a repeat MRI. This would be his fourth MRI for his knee. It is already known that there are degenerative changes and another MRI will not change the course of management. Therefore, I recommend non-certification of the request for the MRI of the right knee without contrast.

03/06/2014: Follow up Examination. **Subjective:** Today the patient notes on a V.A. scale of 0-10 that pain level goes between a 3 ½ and a 7. Again the weather is cold outside and has increased some of this pain and discomfort. He continues to have stiffness associated with the knee. He does note with participation in the Chronic Pain Management Program he is able to accommodate and cope to a greater degree with his daily living activities. He notes that he is much more consistent with his behavior in adapting to his environment. With this in mind he is using less medication management and applying additional home exercise methods to decrease his pain and discomfort. **Physical Examination:** Examination today shows the patient has a ROM of 108 degree flexion with pain at extreme and -1 degree extension. The patient has palpatory soreness and +1

edema noted in the medial and lateral compartments and subpatellarly. There is point tenderness into the anterior tibial plateau. Strength of the knee is reduced secondary to pain and does show a 5-/5 and a 4+/5 at extreme. He continues to have a minimally altered gait. Girth measurements show right thigh 68 cm, left thigh 66.6 cm, right calf 49.5 cm, left calf 48.0 cm. The patient continues with a positive ballottement test. There is point tenderness of the quadriceps insertion that extends into the knee.

Plan: 1. The patient will follow up in 30 days 2. The patient will maintain modified work status for 30 days. 3. The patient will continue medication management. 5. There was a request for a repeat MRI as indicated and agreed with. The MRI has been denied and there will be a reconsideration letter sent in for this.

03/07/2014: Letter of Appeal. stated: The patient has had only two MRI scan of his right knee and three arthroscopic evaluations of the right knee and in all cases the findings have been grossly abnormal. The last arthroscopic evaluation not only revealed lateral meniscal damage, but also indicated chondral damage with chondral debris trailing off of the cartilage where the lateral meniscus repair had been done, but in addition, the patient also now had active synovitis with hypertrophy of the plica synovium. The patient currently has a swollen, tender right knee. The knee is markedly tender to palpation and to movement. It is mildly swollen. He has flexion of 85 degrees and extension of -5 degrees. He has a positive McMurray which lateralizes to the lateral side of the knee. It is my impression that the patient continues with significant pathology in the right knee, and in addition to the meniscus damage that the patient sustained initially with the accident and with three recurrent arthroscopies all demonstrating lateral meniscal pathology and requiring treatment and debridement, the patient is now developing cartilage damage as well as synovial hypertrophy and physiological and anatomical alterations indicative of ongoing damage to injured knee. The MRI scan is being ordered for further diagnosis and management of the patient's ongoing knee injury. It is unclear at this time whether the pain and the inability of this patient to work and to be gainfully employed and to carry on normal daily activities is secondary to further tearing of his meniscus or whether it is due to new chondral disease which would be secondary to the accident and the surgeries that he has had as well as to the hypertrophied synovium, which is exquisitely tender to palpation, as well as to femur and tibial compression with movement and activity. It is my recommendation that the patient be allowed to have the MRI scan to further delineate the extent of the chondral, meniscal damage to the knee as well as the possibility that the plica synovitis as well as other areas of synovial hypertrophy in the knee are now a significant part in the patient's pain syndrome.

03/14/2014: UR performed. Rational for Denial: When considering the date of injury, the mechanism of injury, the numerous MRI studies completed as well as the multiple surgical interventions to include direct visualization as recently as September, 2013 tempered by the physical examination findings in this morbidly obese individual; there is insufficient clinical data presented to suggest the need for an additional imaging study. There is tenderness to the knee, Tennyson joint lines, and some swelling consistent with the multiple surgeries, the noted marked

degenerative changes to include synovitis and chondral surface irregularities. Based on the clinical information noted, there is no indication to suggest that this study would advance the diagnosis of the treatment plan. Therefore, based on the criterion listed, there is insufficient clinical information presented to support this request.

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

The previous adverse determinations are upheld. MRI of the right knee is not felt to be medically necessary. The patient has had three operative procedures at the right knee on 7/12/12, 1/20/13 and 9/11/13. MRI's of the right knee noted are on 10/22/12 and prior to 7/12/12 operative procedure that I do not have with current records. I can see degenerative changes and post operative changes at the right knee that are not expected to change at this point. I would not support medical necessity of an MRI at the right knee to provide any more information that would alter the current treatment plan and advanced care in a positive direction for this patient. For these reasons, Repeat Magnetic Resonance Imaging (MRI) of the Right Knee Without Contrast as Outpatient is not medically necessary at this time and should be denied.

Per ODG:

Indications for imaging -- MRI (magnetic resonance imaging):

- Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption.
- 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.
- 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.
- 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.
- 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).
- *Repeat MRIs:* Post-surgical if need to assess knee cartilage repair tissue. (, 2007) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. (, 2011)

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)**