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Notice of Independent Review Decision

DATE: September 3, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI of the Right Knee without Contrast

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

The reviewer is an orthopedic surgeon with over 50 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured her right knee when her right knee was hit while she was working xx/xx/xx.

09/23/13: The claimant was evaluated for right knee pain. It was noted that her injury occurred on xx/xx/xx and resulted from a direct blow. Her symptoms were located in the right anterior knee, described as moderate in severity. She stated that her pain had been continuing to improve but she was still unable to exercise secondary to discomfort. Past treatment was noted to include physical therapy and wound care with silvadene. On review of systems, she noted soft tissue swelling, a popping sound heard in the knee, muscle cramps, nonspecific pain, swelling, stiffness, and tingling. Her medications included Celebrex, Cymbalta, Lipitor, Lyrica, Temazepam, and Zetia. On exam, she had a healed right knee abrasion. There was diffuse tenderness at the right anterior knee. ROM was full. Motor strength was normal. Special tests: Negative patellar grind, negative patellofemoral apprehension test, negative lateral Apley's grind test of meniscus, negative medial Apley's grind test of meniscus, negative medial McMurray test, negative lateral McMurray test, negative anterior drawer sign, negative Lachman's test, negative pivot shift test, negative posterior drawer sign. No laxity on valgus

stress. No laxity on varus stress. Her gait was normal. Lower extremity compartments were normal. Pulses were normal. Lower extremity peripheral vascular exam was normal. The assessment was contusion of the knee with intact skin surface and joint pain in the right knee. The plan was to obtain MRI scan and followup after.

10/11/13: MRI Right Knee report. IMPRESSION: Prominent degeneration and attenuation of the anterior horn of the lateral meniscus and possibly a small tear of the anterior horn/body junction of the lateral meniscus. Full-thickness cartilage loss along the central to posterior weight-bearing portion of the lateral tibial plateau with very mild subchondral marrow edema. There is also a 3-4 mm focus of high-grade cartilage loss along the central to posterior weight-bearing portion of the lateral femoral condyle. Focally high-grade cartilage loss along the inferior aspect of the median patellar eminence with minimal subchondral marrow edema. Small to moderate joint effusion as well as a popliteal cyst.

10/23/13: The claimant was evaluated for right knee pain rated 2/10, mostly along the medial aspect of the knee. On exam, the right knee abrasions had all healed. There was diffuse tenderness at the anterior portion of the knee. She had full active and passive range of motion. She had normal motor strength. She had negative patellar apprehension and grind. She had tenderness along the medial and lateral articular surface of the distal femur. She had a negative medial McMurray's and lateral McMurray's. She had a negative Lachman's, anterior drawer, and posterior drawer. An in-office cortisone injection was performed using 3 ml of 1% lidocaine injected around the lateral aspect of the knee. Aspiration was performed before injecting 3 ml of 0.25% Marcaine without epinephrine and 40 mg of Kenalog. She was released back to work under full duty and was to return to the clinic in 2-3 weeks. planned to do a knee arthroscopy if she continued to be symptomatic.

11/11/13: The claimant was evaluated. She stated that she had improved overall significantly. She stated that the cortisone injection performed on 10/23/13 helped tremendously. On exam, she had normal heel-to-toe gait. There was very minimal tenderness to palpation at the anterior portion of the right knee. She had full active and passive range of motion of her right knee. She had 5/5 motor strength. She had negative Lachman's, anterior drawer, and posterior drawer. She had a negative medial and lateral McMurray's test. She had stable collateral ligaments that were nontender. She was to return to the clinic on an as-needed basis.

05/20/14: The claimant was evaluated. She noted that her right knee pain had gotten progressively worse over the past two months. She had been walking more to and from her car at work. She was unable to exercise because of the pain. She localized the pain to the medial aspect of the knee. Her medications included Celebrex, Cymbalta, Lipitor, Lyrica, temazepam, and Zetia. On exam, she had a normal heel-toe gait. She had some scarring medially at the right knee. There was tenderness to palpation along the medial joint line. She had full active and passive range of motion of her knee. She had 5/5 motor strength. She had a

negative Lachman's, anterior drawer, and posterior drawer. She had a negative McMurray's and Apley's. Her collateral ligaments were stable to varus and valgus stress testing. X-rays were reviewed. Three views of the right knee were obtained showing no fracture, dislocation, or DJD. wanted to repeat her MRI of the right knee since she had continued to have recurrent episode of pain. He briefly discussed a knee arthroscopy pending the results of the MRI. She was released back to regular duty. She was to follow up upon completion of the MRI.

07/23/14: UR. RATIONALE: Without peer-to-peer review, I cannot recommend a repeat MRI as medically necessary at this time with a good quality MRI of the right knee in October 2013. No recent conservative measures for symptomatology to include anti-inflammatories, activity modification, physical therapy/occupational therapy. Recent x-ray negative. Should further records, diagnostics or peer review become available, I will be happy to take this into consideration.

08/04/14: UR. COMMUNICATION: "reported that he does not know why a request for an MRI was denied; he explained that this individual is being followed for right knee pain, and a previous MRI showed lateral meniscus degeneration and possible small tear but current symptoms are medial, and she had returned to work but developed medial symptoms again and those symptoms persist despite medications and cortisone injection and PT so he said that the options have been done to repeating the MRI or proceeding with diagnostic arthroscopy of the knee; we discussed reasons for repeating the MRI and agreed that I will consider the information given by phone along with information medial with a recommendation concerning the repeat MRI of the left knee." RATIONALE: Applicable clinical practice guidelines reserve repeating the MRI of the right knee for instances in which there has been a significant change in the individual's condition since a previous MRI, such as a new injury. This individual underwent right knee MRI just over nine months ago. She has not had a new injury, but her symptoms have varied according to her activity level. There is no report that the previous MRI was of inadequate technical quality, so the medical necessity for repeating the MRI of her right knee is not clearly established after speaking with the treating physician by phone.

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

The previous adverse determinations are upheld. According to ODG, repeat MRI is usually reserved post-surgical if there is a need to assess knee cartilage repair tissue or for instances in which there has been a significant change in symptoms. According to recent records the claimant has complaints of increased pain within the last two months, but clinical examination did not demonstrate any significant changes. It is also noted that her pain varies with activity. There is also a lack of documentation of recent conservative measures for symptomatology. Therefore, the request for Repeat MRI of the Right Knee without Contrast is not found to be medically necessary.

ODG:

MRI's (magnetic	Indications for imaging -- MRI (magnetic resonance imaging):
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resonance imaging)	<p>- Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption.</p> <p>- 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.</p> <p>- 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.</p> <p>- 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.</p> <p>- 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).</p> <p>- <i>Repeat MRIs:</i> Post-surgical if need to assess knee cartilage repair tissue.</p> <p>(Ramappa, 2007) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. (Weissman, 2011)</p>
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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)