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Notice of Independent Review Decision

**August 27, 2014**

**IRO CASE #:**

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

Re-imaging MRI of the left knee

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

Orthopedic Physician

**REVIEW OUTCOME:**

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

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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who injured her left leg and hand on xx/xx/xx. She landed on the left leg resulting in hematoma at the lateral left lower extremity and left knee pain.

**PRE-INJURY RECORDS**

On July 28, 2010, performed a left knee arthroscopic surgery for the postoperative diagnosis of patellofemoral chondromalacia with lateral mal-tracking, lateral meniscus tear, small inter-articular loose bodies and anteromedial/anterolateral compartment synovitis and fat pad hypertrophy. Per the procedure details, the scope was introduced medially initially. The suprapatellar pouch had a little synovitis. The patellofemoral articulations were obscured by synovial and fat pad hypertrophy, and the resector was used to perform a partial fat pad excision as well as resection of the synovium from the anteromedial and anterolateral

compartments. The patellofemoral articulation had diffuse chondromalacia over the medial facet, but the lateral facet had large fissures and chondral delamination, which was also evident on the far edge of the lateral femoral condyle, indicating severe rubbing. There was quite a bit of excessive tilt on taking the knee through full range of motion (ROM), with moderate subluxation of the lateral facet over the edge of the LFC. The LCFL was palpably thickened and tight. The scope was placed in the lateral compartment; where there was found to be some diffuse degenerative change as well as a linear undersurface tear of the lateral meniscus. A lateral meniscectomy was performed. The medial compartment showed similar arthritic changes, consistent with grade I and grade II chondromalacia. The medial meniscus was somewhat thin and brittle but did not have an obvious tear. There was a thin but otherwise normal-appearing anterior cruciate ligament (ACL). The lateral gutter was extensively cleared of synovium and soft tissue using the resector. The ArthroCare wand was then used to perform a lateral release, extending from the edge of the vastus lateralis fascia distally to the anterolateral portal. The release was full and complete.

On September 28, 2010, noted the patient's left knee was doing much better. Occasionally, the patient felt a little twinge in the knee. She noticed quite a bit of difficulty going up and down the steep stairs. She had completed her therapy. felt the patient should expect to have some intermittent symptoms particularly during the fall and winter but overall she would improve to a degree. The arthritis symptoms might continue to bother her.

## **POST-INJURY RECORDS**

On May 29, 2014, evaluated the patient for thigh injury and left knee instability, pain, popping and stiffness. Gait was antalgic related to feeling of unsteadiness in the left knee. Examination showed bruising at the upper leg, tenderness in the left knee and abnormal flexion and extension of the left knee. X-rays showed history of meniscus and ACL injury and tears. The diagnosis was lower leg contusion. administered injection ketorolac tromethamine, prescribed Naprosyn and Robaxin and recommended using crutches and a knee splint.

X-rays of the left knee dated June 3, 2014, was negative for fracture, dislocation, destructive bony process or bone, joint or soft tissue abnormality.

On June 2, 2014, evaluated the patient for left knee pain, bruising and swelling. On examination, there was bruising present at the upper leg, tenderness in the left knee and abnormal left knee extension and flexion. Patellar crepitus was present along with swelling at the foot. discontinued naproxen and advised the patient to take over-the-counter (OTC) Tylenol. A magnetic resonance imaging (MRI) of the left knee was recommended to rule out meniscal tear.

On June 5, 2014, MRI of the left knee showed the following findings: (1) The lateral meniscus was very diminutive in size with absence of the posterior horn and most of the adjacent body similar to the prior exam and consistent with a subtotal meniscectomy. The posterior horn and posterior body of the medial

meniscus was also diminutive in size suggestive of a partial meniscectomy. That was also stable from the prior exam. (2) A complete tear of the ACL was noted which was chronic and was present on the prior exam. (3) A complete tear of the lateral retinaculum was noted at the patellar attachment which was not present on the prior exam. Fluid partially herniated through the retracted retinaculum and adjacent patella. (4) There was some minor loss of articular cartilage that might be present over the medial patellar facet. There was mild loss of cartilage seen in the medial compartment. There was more pronounced loss of cartilage seen in the lateral compartment. (5) Tiny osteophytes were seen in the medial and lateral compartments. Reactive marrow edema was seen in the posterior aspect of the lateral tibial plateau. Those changes were all similar to the prior examination. (6) Soft tissue edema was noted.

On June 9, 2014, the patient reported she was unable to bear weight. reviewed the MRI findings that showed lateral retinaculum tear and referred the patient for an orthopedic evaluation.

On June 11, 2014, evaluated the patient for left knee problem. Examination of the left knee showed 1+ effusion, tenderness of the lateral joint line, pain at extreme limits of range (posterolateral joint line with deep flexion), positive McMurray's test, flexion strength of 4/5 and hamstrings weakness. The patient was having mechanical sharp pain and buckling in the left knee. Hematoma on the leg was improving slowly. diagnosed derangement of the left knee, strain of the left knee and contusion of the lower leg. He recommended obtaining MRI of the left knee and referred the patient for physical therapy (PT).

From June 24, 2014, through July 15, 2014, the patient attended two sessions of physical therapy (PT) consisting of ultrasound and therapeutic exercises.

On July 17, 2014, the patient reported she was concerned with her left lower leg. PT went well and the knee was doing better. She had popping/clicking, swelling and buckling. Associated symptoms included swelling and ecchymosis. On examination, there was pain at extreme limits of range, tenderness of the fat pad and tenderness of the medial (+) and lateral joint line (+++). McMurray's was negative. Left knee was feeling better. Hematoma from saphenous disruption was slowly evolving/improving. The radiologist misinterpreted the previous lateral release as a lateral retinacular tear that was not an acute finding. She also had a previous PLM. She had finished PT. diagnosed sprain of the left knee, left saphenous hematoma and contusion of lower leg and recommended returning to office as needed.

Per the utilization review dated July 25, 2014, the request for MRI of the left knee was denied based on the following rationale: *“Official Disability Guidelines-Treatment in Workers’ Compensation indicates repeat MRI studies would be supported postoperatively when there is a need to assess knee cartilage repair tissue. The records do not reflect the claimant has undergone any surgery or has any increased subjective complaints of pain. The records do not reflect there are*

*signs of internal derangement on physical examination. The request for an MRI of the left knee was not certified.*

Per a reconsideration review dated August 5, 2014, the appeal for a repeat left knee MRI without contrast was denied based on the following rationale: *“This is a non-certification of an appeal of an outpatient left knee repeat MRI without contrast. The previous non-certification on July 21, 2014, was due to lack of documentation of any surgery or any increased subjective complaints of pain as well as lack of signs of internal derangement on physical examination. The previous non-certification is supported. Additional records were not provided for review. The guidelines indicate repeat MRI evaluations would be supported for postoperative knees of assessment of cartilage repair tissue and routine use of an MRI for followup of asymptomatic claimants following knee arthroplasty is not recommended. There are no physical examination findings to support a repeat examination. The request for an appeal of an outpatient left knee repeat MRI without contrast is not certified.”*

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

The requested repeat MRI of the left knee cannot be recommended as medically necessary. This claimant already underwent a left knee MRI on 6/5/14, and there is no history of an interval injury since that time. The records suggest that recommended an MRI of the left knee on 6/11/14 even though one had been performed six days before. It is not clear if was aware that an MRI had already been performed. The MRI was noted to show a chronic anterior cruciate ligament tear as well as post-operative changes after prior meniscectomy and arthritic change. These findings noted on the prior MRI would certainly seem to explain the claimant’s symptoms. For all of these reasons, a new MRI would not seem to be indicated at this time based on the information reviewed.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**