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Date notice sent to all parties: 08/28/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

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

☐ Upheld (Agree)

☐ Overturned (Disagree)

X Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

MRI of the XX ankle/foot – Upheld
MRI of the XX knee – Overturned

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX examined the patient on XXXX. XXXX was diagnosed with a XX knee sprain, XX ankle sprain, and a contusion of the XX lower leg. XXXX. XXXX had pain to XXXX XX foot up to the shin and knee. XXXX had been diagnosed with a sprain in the ER. The patient then attended therapy XXXX for a total of 6 sessions based on the documentation. The patient was seen by XXXX. XXXX was injured on XXXX. XXXX had less XX ankle swelling, but XXXX was not better. XXXX XX knee pain was unchanged, as was the swelling. XXXX had to stop taking oral XX due to XX XX XX and XXXX was currently on light duty. XXXX had pain rated at XX/XX when XXXX tried to ambulate. XXXX was XXXX inches tall and weighed XXXX pounds. XXXX had XX XX and medial knee pain that radiated to the XX leg and ankle. XXXX claimed decreased ROM and tenderness. XXXX had XX knee swelling and diffuse tenderness. ROM was limited and XX XX XX was negative. XX and XX XX were positive. There was swelling of the XX mid shin and what appeared to be XX. ROM was full with pain and strength was normal. In the XX ankle, there was XX and XX XX tenderness, but not at the Achilles'. ROM was limited in all planes. The assessments were sprains of the XX knee and ankle. XXXX and work restrictions were continued. MRIs of the XX ankle and XX knee were recommended at that time. On XXXX, a preauthorization request was submitted for XX knee and ankle MRIs. On XXXX, XX provided an adverse determination notice for the MRIs of the XX ankle/foot and XX knee. XXXX examined the patient on XXXX. The assessments were contusion of the XX lower leg, XX ankle sprain, and XX knee sprain. XXXX were prescribed. It was noted the patient still was not improving, so MRIs of the XX ankle and knee were also recommended. Modified duty was continued. On XXXX still had significant swelling, pain and limited ROM. They would consult an orthopedist for help and the MRIs were again recommended. Home exercises and stretching were also recommended. Modified duty was continued. On XXXX provided another adverse determination for the requested MRI of the XX ankle/foot and an MRI of the XX knee. XXXX examined the patient on XXXX. XXXX had mild swelling and effusion of the XX ankle and ROM was normal. In the knee, ROM was XX-XX degrees with pain on XX. XX was positive. X-rays that day were negative. Continued therapy was recommended, as well as an MRI of the XX knee. XXXX then followed-up with the patient on XXXX. XXXX had been denied XXXX XX knee MRI and had pain rated at XX/XX. XXXX noted XXXX had finished therapy and still had feelings of locking, catching, and popping in the XX knee. XXXX also still had XX ankle pain. The XX knee MRI was again recommended. On XXXX, XXXX still had decreased ROM and weightbearing and pain with walking. At that time, the patient had full ROM of the XX ankle. XXXX had XX and XX XX knee tenderness and limited ROM. As of XXXX, XXXX had not heard back about the MRI referral. XXXX continued with moderate XX ankle and knee pain. The XX ankle had full ROM with pain and the XX knee still had limited ROM in all planes.

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

As noted above, the most recent examination on XXXX did reveal that there still was XX and XX tenderness and limited range of motion with regards to the XX knee. The XX ankle had full range of motion with pain. There have also been findings throughout the chart of questionable XX findings. Per the ODG, Ankle and Foot Chapter, indications for MRI include suspected XX injury or XX, pain of uncertain etiology, and signs and symptoms and exam findings consistent with XX XX, XX XX, or strong suspicion of XX XX or XX XX. The ODG also notes MRI is not advised for common routine ankle sprains showing normal healing progression. As of the XXXX note, the patient had full ROM in the XX ankle, but with pain. There is not enough objective medical documentation provided to support that anything more than a simple XX ankle sprain has been sustained nor to support ongoing or objective dysfunction in the ankle. Based on the documentation reviewed, it does not appear the patient meets the above-mentioned criteria per the ODG for an MRI of the XX foot/ankle. Per the ODG, Knee and Leg Chapter, indications for MRI include acute trauma to the knee, including significant trauma or if a XX knee dislocation or if ligament or cartilage damage is expected, as well as for non-traumatic knee pain. With regard to the XX knee, XXXX has continued to have pain and decreased ROM despite physical therapy, modified work duty, and the use of medications. Given the length of time of XXXX symptoms, in my opinion, this is also an indication for an MRI scan of the XX knee. Therefore, at this time, the recommended MRI of the XX foot/ankle is not medically necessary, appropriate, or in accordance with the ODG and the previous adverse determinations should be upheld. However, the recommended MRI scan of the XX knee is medically necessary, appropriate, and in accordance with the ODG and the previous adverse determinations should be overturned.

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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**