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Notice of Independent Review Decision

DATE OF REVIEW: April 7, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Magnetic resonance imaging (MRI) of the left knee without contrast (99080).

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

M.D., Board Certified in Physical Medicine and Rehabilitation and Pain Medicine.

REVIEW OUTCOME

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

☒**Upheld** **(Agree)**

☐Overturned (Disagree)

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

The requested MRI of the left knee (99080) without contrast is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx. According to the documentation submitted for review, the patient presented on 12/29/14 with reports of occasional knee pain when he is not wearing his brace. He was participating in physical therapy and requested additional sessions. He was assessed with a strain of the left knee and recommended for a physical therapy referral and magnetic resonance imaging (MRI) of the left knee. On 1/15/15 the patient presented for a follow-up and stated that physical therapy is helping very little. His examination noted effusion grade 1 and swelling, but no erythema, no genu valgum, no genu varum and no joint hypertrophy. He had tenderness diffusely noted at the anteromedial aspect, medial joint line and medial collateral ligament. Additionally, he had limited range of

motion in all planes with a positive medial McMurray test. The plan of care included radiographs of the knee and use of the knee brace with modified activities.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. The denial letter dated 3/2/15 indicates that there is no detail provided of what specific diagnosis is trying to be ruled out, particularly since the diagnosis has been listed as a left knee strain.

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

Per Official Disability Guidelines (ODG), indications for magnetic resonance imaging (MRI) include: *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., Pellegrini-Stieda disease, joint compartment widening).*

According to ODG, without having any documentation of initial imaging, to include plain x-rays to rule out fracture or dislocation, the requested MRI of the left knee is not medically necessary at this time. In addition, without having an updated comprehensive examination to review the patient's pathology following conclusion of his physical therapy, the MRI is not medically necessary. For the reasons provided, the medical necessity for the requested services has not been established. In accordance with the above, I have determined that the requested MRI of the left knee without contrast is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)**