**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**
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Notice of Independent Review Decision

**DATE OF REVIEW:** March 6, 2012

**IRO CASE #:**

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

Supartz Injection, Left Knee. CPT Code: J7321.

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

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Medical records from the URA/Carrier include:

- Official Disability Guidelines, 2008
- 02/16/11
- 11/09/11
- 12/28/11
- 12/28/11, 01/13/12

Medical records from the Provider include:

- 04/01/09, 05/20/09, 07/08/09, 08/05/09, 09/02/09, 09/30/09, 10/14/09, 11/18/09, 12/30/09, 01/27/10, 02/24/10, 04/21/10, 05/19/10, 07/14/10, 09/01/10, 10/06/10, 12/01/10, 02/16/11, 05/25/11, 08/10/11, 09/07/11, 09/14/11, 09/21/11, 11/09/11, 12/28/11

**PATIENT CLINICAL HISTORY:**

To Whom It May Concern:

I have had the opportunity to review medical records on this patient.

The records indicate a date of injury of xx/xx/xx, and include a reported injury to the left knee. The initial medical reports in this case are not available.

The patient was treated for post traumatic arthritis, and underwent multiple injections. A total of no fewer than 20 injections appear to have been given.

More recently, a series of Supartz injections were performed, with a third injection on September 21, 2011.

The patient returned six weeks later citing recurrence of her symptoms. Another series of Supartz injections were requested, but non-certified by the carrier citing ODG Guidelines.

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

The denial in this case should be upheld. A repeat series of injections should not be approved unless there is documented significant improvement in symptoms for six months or more.

Therefore, the ODG Guidelines have not been met in this case, and the denial appears appropriate.

I trust that this will be sufficient for your needs.

**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)