

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 13, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

In office Synvisc One injection for the left knee

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

This physician is Board Certified as an Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

08/02/11: Follow UP and Procedure Note
08/30/11: Follow Up
09/29/11: MRI Left Knee
10/04/11: Follow Up
10/27/11: Pre Op Visit
11/02/11: Operative Report
11/03/11: Rehab Report
11/04/11: Post Op Visit
11/07/11: Rehab Daily Note
11/09/11: Rehab Daily Note
11/11/11: Rehab Daily Note
11/15/11: Post Op Visit
11/15/11: Rehab Daily Note
11/16/11: Rehab Daily Note

11/18/11: Rehab Daily Note
11/21/11: Rehab Daily Note
11/22/11: Rehab Daily Note
11/28/11: Rehab Daily Note
12/02/11: Rehab Daily Note
12/05/11: Rehab Progress Note
12/13/11: Follow Up and Procedure Note
01/10/12: Follow Up and Procedure Note
02/07/12: Follow Up and Procedure Note
05/08/12: Follow Up and Procedure Note
05/18/12: MRI Left Knee
05/22/12: Follow Up and Procedure Note
06/12/12: Pre Op Visit
06/21/12: Operative Report
06/22/12: Post Op Visit
06/22/12: Rehab Report
06/25/12: Rehab Daily Note
06/27/12: Rehab Daily Note
06/29/12: Rehab Daily Note
07/02/12: Rehab Daily Note
07/05/12: Rehab Daily Note
07/09/12: Rehab Daily Note
07/10/12: Post Op Visit
07/10/12: Rehab Daily Note
07/12/12: Rehab Daily Note
07/16/12: Rehab Daily Note
07/18/12: Rehab Progress Note
07/24/12: Follow Up and Procedure Note
08/21/12: Follow Up and Procedure Note
09/18/12: Follow Up and Procedure Note
12/18/12: History and Physical
02/12/13: History and Physical for right elbow
02/19/13: History and Physical for right elbow
02/26/13: History and Physical for right elbow
03/07/13: History and Physical for right elbow
03/19/13: EMG/NCV for the Upper Extremities
05/21/13: History and Physical
07/27/13: WC Precertification
08/08/13: UR performed
08/28/13: Letter
08/29/13: Letter
09/09/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx.

On August 2, 2011, the claimant was re-evaluated for left knee pain. On physical examination there was full ROM of the left knee with moderate crepitation and

minimal effusion. There was some tenderness along the lateral joint line and minor tenderness medially. Procedure Note: Intraarticular steroid injection. Depo-Medrol 80 mg, #1, tolerated well.

On September 29, 2011, MRI of the Left Knee, Impression: 1. Truncation of the body of the medial meniscus and some of the adjacent posterior horn is believed to reflex partial meniscectomy. Correlation with details of surgical history. In the posterior horn, signal contacts the free edge, but no joint fluid extends into it to indicate a definite tear. If this signal was present prior to the previous date of arthroscopy, this can persist and mimic a tear and does not necessarily indicate a tear as such, and if that was the case, would be thought to be preexisting degenerative signal. If this is new from previous preoperative MRI, then it suggests a tear. 2. Intact lateral meniscus. 3. Knee joint effusion. 4. Evidence of prior arthroscopy.

On November 2, 2011, Operative Report. Postoperative Diagnosis: 1. Internal derangement, left knee. 2. Synovitis of the anterior and lateral compartments. 3. Grade-II to III chondromalacia of the inferior pole of the patella. 4. Recurrent medial meniscal tear. Operations Performed: 1. Diagnostic arthroscopy, left knee. 2. Partial synovectomy of the anterior and lateral compartments. 3. Shaving Chondroplasty of the inferior pole of the patella. 4. Recurrent partial medial meniscectomy.

On December 5, 2011, the claimant underwent a physical therapy re-evaluation where it was reported he had been seen from November 3, 2011 to December 5, 2011 for a total of 12 visits. Compliance and Progress were reported to be excellent. It was reported that all goals were met and Recommendation was to discharge to a home exercise program.

On December 3, 2011, the claimant was re-evaluated who reported 80% improvement with so residual pain. Procedure Note: Intraarticular steroid injection, 80-mg Depo-Medrol.

On May 18, 2012, MRI Left Knee, Impression: 1. Evidence of prior surgery. 2. Increased signal on the posterior horn of the medial meniscus where there is degenerative amorphous signal contacting the superior articular surface which can indicate some degenerative fraying or tearing although no linear tear is demonstrated and fluid in the joint line does not extend into the substance of the meniscus without a frank tear. This signal has increased from the prior study. 3. There is a knee joint moderate effusion.

On June 21, 2012, Operative Report. Postoperative Diagnosis: 1. Internal derangement, left knee. 2. Myosynovitis with grade-II chondromalacia of the medial femoral condyle. 3. Recurrent lateral meniscus tear. Operations Performed: 1. Diagnostic arthroscopy, left knee. 2. Shaving Chondroplasty with partial synovectomy. 3. Revision posterior horn lateral meniscal repair.

On July 10, 2012, the claimant was re-evaluated 2 weeks post op. On physical examination he was moving the leg well with full extension to greater than 100 degrees of flexion. He did have some mild medial and lateral joint line tenderness. Plan: continue PT.

On July 18, 2012, the claimant underwent a physical therapy re-evaluation where it was reported he had been seen from June 22, 2012 to July 18, 2012 for a total of 12 visits. Compliance and Progress were reported to be excellent. It was reported that the claimant was progressing well with PT and reaching most goals but would benefit from continued PT to address remaining strength and functional limitations for return to work.

On September 18, 2012, the claimant was re-evaluated for continued left knee pain and some weakness with activity. It was reported the claimant was wearing a brace except for when at home. It was also reported he was taking Ibuprofen for pain but does not need it regularly. On physical examination there was no effusion, or tenderness. ROM was to 120 degrees. Plan: continue brace, Ibuprofen, and home exercises.

On May 21, 2013, the claimant was re-evaluated for left knee pain described as painful while sitting and comes and goes at the end of the day. Pain located on the lateral side of the knee. Treatment history included 2 previous scopes, multiple steroid injections without relief, PT, and medication without relief. On physical examination there was no edema or joint effusion. There was moderate tenderness at the lateral facet of the patella, medial joint line and lateral joint line. ROM of the knee is 0 to 120. Patellar compression test was positive; McMurray's test produced mild LJO pain. Anterior drawer sign was negative. Lachman's sign was negative. Valgus and Varus stress tests showed no laxity. X-rays of the left knee showed moderate narrowing and spurring of joint space in the medial compartment and patellofemoral compartment narrowing. Assessment: Internal Derangement Left Knee, Osteoarthritis of Left Knee. Plan: Recommend Synvisc One injection. Begin Celebrex. Fit with new wrap on hinged knee brace due to previous brace being worn out.

On August 8, 2013, completed a UR. Rationale for Denial: The guidelines would not support hyaluronic acid injections unless there was documentation of symptomatic osteoarthritis noted. The claimant has full functional range of motion with no recent documentation of formal physical therapy provided in the records. The claimant is under xx years of age and the guidelines recommend the claimant be over xx years of age for Synvisc injections. The guidelines recommend five of the following: bony enlargement, bony tenderness, crepitus, SE rate of less than 40, less than 30 minutes of morning stiffness, no palpable warmth of the synovium, over xx years of age, and a rheumatoid factor of less than 1.4 40 titer. Synovial fluid signs should be noted however a synovial study is not noted in the records provided for review. The claimant has been documented to have no significant functional limitation in range of motion or weakness on examination. The official radiology report indicating evidence of severe osteoarthritis of the

knee has not been noted. The request for a left knee Synvisc injection is not certified.

On August 28, 2013, wrote a letter indicated that the claimant had been treated with arthroscopy procedures, oral medications, intra-articular steroid injections, physical therapy and activity modification but continues to have knee pain. presented the argument that although the claimant does not necessarily correlate with the "age" of his joint as the claimant is required to perform a higher level of physical activity in his job than most. He continued to argue that the intense level of activity the claimant has to participate in can easily exacerbate the symptoms of post-traumatic arthritis and cause a relatively young patient to experience discomfort and limitations in function typically seen in numerically older patients. opined that the use of the Synvisc One to the left knee for the treatment of moderate post-traumatic degenerative joint disease is less aggressive and less costly than alternative methods including additional surgical procedures.

On August 29, 2013, wrote a letter indicating the following functional limitations: standing and sitting for prolonged periods during normal working conditions; and unable to run, jog, play basketball, and climb ladders or stairs without pain, weakness or difficulty. He reported experiencing knee stiffness every single morning when he wakes that takes 30-60 minutes for the joint to loosen. He also stated he did have success with physical therapy, but attempted over a 2 month trail of NSAID treatment (Mobic and Celebrex) without success and very little relief.

On September 9, 2013, completed a UR. Rationale for Denial: Additional documentation provided for review includes an appeal letter from the treating clinician as well as the patient, noting the patient has had symptoms despite conservative treatment failure with oral medications, corticosteroid injection, and prior therapy. The previous denial is supported as recent documentation of at least three months of failure formal physical therapy and associated progress notes have not been provided. Radiology documentation of osteoarthritis has not been noted in the recent records provided. There is no documentation of severe symptomatic osteoarthritis with at least five of the following criteria, as recommended by the Guidelines in the American College of Rheumatology, including bony enlargement, bony tenderness, crepitus, sedimentation rate of less than 40, less than 30 minutes of morning stiffness; no palpable warmth of synovium, age over xx years, rheumatoid factor less than 1:40 titer, and synovial fluids documenting clear fluid of normal viscosity and a white blood cell count of less than 20000. Although the patient has had subjective symptoms, without full documentation recommended by the Guidelines, hyaluronic acid injections cannot be supported at this time.

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

The previous adverse determinations are overturned. The claimant has undergone 2 surgeries, the last showing chondromalacia. The claimant has also undergone physical therapy post op both times, used NSAIDS without relief,

undergone intra-articular steroid injections has functional limitations and complaints of morning stiffness in his left knee. The claimant job requires a high demand of physical activity and therefore, I do not agree with the ODG recommendation of over xx years of age. Not all the ODG criteria are met, however, in this particular situation, not all the criteria are applicable. After careful review of all the documentation provided for review and the ODG guidelines, I believe the request for In office Synvisc One injection for the left knee is medically reasonable.

PER ODG:

Criteria for Hyaluronic acid injections:

- Patients experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative nonpharmacologic (e.g., exercise) and pharmacologic treatments or are intolerant of these therapies (e.g., gastrointestinal problems related to anti-inflammatory medications), after at least 3 months;
- Documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria, which requires knee pain and at least 5 of the following:
 - (1) Bony enlargement;
 - (2) Bony tenderness;
 - (3) Crepitus (noisy, grating sound) on active motion;
 - (4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr;
 - (5) Less than 30 minutes of morning stiffness;
 - (6) No palpable warmth of synovium;
 - (7) Over 50 years of age;
 - (8) Rheumatoid factor less than 1:40 titer (agglutination method);
 - (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm³);
- Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease;
- Failure to adequately respond to aspiration and injection of intra-articular steroids;
- Generally performed without fluoroscopic or ultrasound guidance;
- Are not currently candidates for total knee replacement or who have failed previous knee surgery for their arthritis, unless younger patients wanting to delay total knee replacement. ([Wen, 2000](#))
- Repeat series of injections: If documented significant improvement in symptoms for 6 months or more, and symptoms recur, may be reasonable to do another series. No maximum established by high quality scientific evidence; see [Repeat series of injections](#) above.
- Hyaluronic acid injections are not recommended for any other indications such as chondromalacia patellae, facet joint arthropathy, osteochondritis dissecans, or patellofemoral arthritis, patellofemoral syndrome (patellar knee pain), plantar nerve entrapment syndrome, or for use in joints other than the knee (e.g., ankle, carpo-metacarpal joint, elbow, hip, metatarso-phalangeal joint, shoulder, and temporomandibular joint) because the effectiveness of hyaluronic acid injections for these indications has not been established.

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)**