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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/02/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Synvisc One Left Knee Injection

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

Board Certified Orthopedic Surgery

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)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 06/03/13, 07/01/13

Office note dated 05/28/13, 05/13/13, 04/29/13, 07/05/12, 04/19/12, 05/21/13, 05/31/12

Operative note dated 03/16/12

MRI left knee dated 05/21/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The patient underwent left knee arthroscopy with partial medial meniscectomy, debridement of chondromalacia medial femoral condyle on 03/16/12 followed by postoperative physical therapy. Per note dated 04/29/13, the patient states that last Tuesday he stood up and had a sharp pain in his left knee. On physical examination there is no effusion. X-rays reportedly show no bony abnormality. MRI of the left knee dated 05/21/13 revealed medial meniscal tear or scar at the site of previous meniscectomy. There has been very significant change in the appearance of the ACL since the previous exam. A few of the fibers appear to be intact but the ligament is predominantly absent. The distal end of the vastus medialis muscle belly appears atrophic though not completely included in the field of view. Office note dated 05/28/13 indicates that there is probable complex pain syndrome with atrophy of the vastus medialis possibly secondary to nerve injury. On exam he has no major effusion. He has some pain of his medial femoral condyle and some of the medial and lateral joint line.

Initial request for Synvisc one left knee injection was non-certified on 06/03/13 noting that the

documentation submitted for review does not support the request as there is no indication that the patient has osteoarthritis of the knee. The denial was upheld on appeal dated 07/01/13 noting that imaging study evidence, as documented in the previous adverse determination reporting the patient presents with osteoarthritis was not noted in the clinical documents. Furthermore, the clinical notes do not evidence the patient is utilizing any other conservative cares for his pain complaints. reported weightbearing x-rays revealed only mild narrowing.

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

The patient sustained injuries on xx/xx/xx and underwent left knee arthroscopy on 03/16/12 followed by a course of postoperative physical therapy. The patient's physical examination fails to establish the presence of significantly symptomatic osteoarthritis, as required by the Official Disability Guidelines. Additionally, there is no evidence of osteoarthritis on imaging studies/radiographic reports to support the request. As such, it is the opinion of the reviewer that the request for Synvisc one left knee injection is not recommended as medically necessary.

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

ACOEM-AMERICA 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)