

IRO REVIEWER REPORT TEMPLATE -WC

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Notice of Independent Review Decision

Date notice sent to all parties:

November 12, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Corticosteroid injection to the Left Knee under Fluoroscopic Guidance, as Outpatient.

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

Board Certified Anesthesiologist; Board Certified Pain Medicine

REVIEW OUTCOME:

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

Upheld (Agree)

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:

Chiropractic note dated 08/08/13
Chiropractic note dated 08/14/13
Chiropractic note dated 08/15/13
Chiropractic note dated 08/19/13
Chiropractic note dated 08/21/13
Chiropractic note dated 08/27/13
Chiropractic note dated 08/31/13
X-ray of the left knee dated 08/05/13
MRI of the left knee dated 08/05/13

Clinical note dated 07/08/13
Clinical note dated 07/30/13
Clinical note dated 08/21/13
Clinical note dated 10/15/13
Adverse determinations dated 09/06/13 & 10/23/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury regarding her left knee. The x-rays of the left knee dated 08/05/13 revealed no bony or joint abnormalities. The MRI of the left knee dated 08/05/13 revealed no internal derangement. No meniscal issues were noted. All ligamentous structures were noted to be intact. The clinical note dated 07/08/13 indicates the patient complaining of 3-7/10 pain at the left knee. The patient was noted to be utilizing a brace at that time. Strength deficits were noted at the left knee that were rated as 5-/5. The clinical note dated 07/30/13 indicates the patient having difficulty squatting more than 75 degrees secondary to pain. The patient was instructed to initiate physical therapy at that time. The clinical note dated 08/21/13 indicates the patient continuing with a constant, aching, stabbing, and burning sensation. The patient rated the pain as 9/10 at that time. The therapy note dated 09/12/13 indicates the patient having completed 9 chiropractic therapy sessions to date. The clinical note dated 10/28/13 indicates the patient continuing with left knee pain. Tenderness was noted upon palpation at the IT band and the trochanteric bursa. The patient was able to demonstrate full range of motion throughout the left lower extremity. 4/5 strength was noted with the hip flexors and the iliopsoas muscle.

The previous utilization review dated 09/06/13 resulted in a denial for a Corticosteroid injection at the left knee secondary to no significant pathology was confirmed.

The utilization review dated 10/23/13 resulted in a denial for an injection as no clinical indications were present upon clinical exam.

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

The documentation submitted for review elaborates the patient complaining of left knee pain. A Corticosteroid injection would be indicated at the knee provided the patient meets specific criteria to include significant findings indicating bony enlargement, bony tenderness, crepitus, palpable warmth, the patient noted to be older than 50 years of age, significant synovial fluid signs, and an RH factor of less than 1:40 titer. As such, it is the opinion of this reviewer that the request for a Corticosteroid injection at the left knee under fluoroscopic guidance as an outpatient is not medically necessary.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Corticosteroid injections

Recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. The beneficial effect could last for 3 to 4 weeks, but is unlikely to continue beyond that. Evidence supports short-term (up to two weeks) improvement in symptoms of osteoarthritis of the knee after intra-articular corticosteroid injection. The number of injections should be limited to three. (Leopold, 2003) (Arroll-BMJ, 2004) (Godwin, 2004) The short-term benefit of intra-articular (IA) corticosteroids in treatment of knee osteoarthritis is well established, and few side effects have been reported. Longer-term benefits have not been confirmed. Comparisons of IA corticosteroids showed triamcinolone hexacetonide was superior to betamethasone for number of patients reporting pain reduction up to four weeks post injection. The response to hyaluronan/hylan products appears more durable, compared to corticosteroids. (Bellamy-Cochrane, 2005) (Bellamy, 2006) In a randomized controlled trial comparing a new reciprocating procedure device (RPD) to the traditional syringe for injection of intraarticular corticosteroid, the RPD significantly reduced patient pain and procedure time. (Bankhurst, 2007) Intra-articular injections of hyaluronate are associated with delayed onset of analgesia but a prolonged duration of action vs injections of corticosteroids. (Zhang, 2008) Intra-articular corticosteroid injections help to relieve pain and reduce swelling in osteoarthritis of the knee and typically yield improvement within 24 hours that lasts 4 to 8 weeks. Repeated injections to the knee may not accelerate disease progression for osteoarthritis. (Stephens, 2008) A meta-analysis of clinical trials concluded that, from baseline to week 4, intra-articular corticosteroids appear to be relatively more effective for pain than intra-articular hyaluronic acid, but by week 4, the 2 approaches have equal efficacy, and beyond week 8, hyaluronic acid has greater efficacy. (Bannuru, 2009) This study demonstrates the potential chondrotoxicity associated with intra-articular bupivacaine use in arthritic knee joints, particularly when given with a corticosteroid. Although these findings seem to be subtle and are probably subclinical after just 1 injection, they indicate the possible spectrum of iatrogenic injury that may be caused by repeated injections of local anesthetics commonly used to treat articular pain. (Chu, 2010) Although there are several corticosteroid compounds available for use in the IA injection of the knee joint, there is scant comparative data for the compounds, although there appears to be a tendency for trimacinolone to be the most efficacious compound. There is no evidence to suggest that doses other than those recommended by the manufacturers for each compound should be administered. There is too little experimental or observational data to draw any conclusions as to an optimal frequency of IA corticosteroid injection, and current usage patterns are determined by practitioner opinion. Finally, IA injection of corticosteroid is a treatment adjunct and should not be used as monotherapy for patients with chronic, stable OA. (Douglas, 2012) This systematic review looking for predictors of response from intra-articular steroid injections in knee osteoarthritis suggested that absence of synovitis, presence of effusion, and withdrawal of fluid from the knee were all predictive of a better response. Increasing efficacy was also associated with increasing severity of radiographic degeneration and

increasing severity of pain, stiffness, and loss of function. Duration of symptoms was not associated with response. (Maricar, 2013)

Imaging guidance for knee joint injections: In the knee, conventional anatomical guidance by an experienced clinician is generally adequate. Ultrasound guidance for knee joint injections is not generally necessary. For more information and references, see Ultrasound, diagnostic.

Criteria for Intraarticular glucocorticosteroid injections:

· 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);
- Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen);
- Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease;
- Intended for short-term control of symptoms to resume conservative medical management or delay TKA;
- Generally performed without fluoroscopic or ultrasound guidance;
- Absence of synovitis, presence of effusion preferred (not required);
- Aspiration of effusions preferred (not required);
- Only one injection should be scheduled to start, rather than a series of three;
- A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response;
- With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option;
- The number of injections should be limited to three.