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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/20/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: synvisc injection to the right knee

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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. It is the opinion of the reviewer that the request for synvisc injection to the right knee is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient reports that he felt a pop in the right knee walking downstairs. MRI of the right knee dated 05/08/14 revealed normal marrow signal, normal articular cartilage, no abnormal signal within the menisci, ligaments or tendons. Note dated 07/15/14 indicates that the patient has completed approximately one month of physical therapy (10 sessions) with good attendance and compliance with a home exercise program. Progress report dated 09/15/14 indicates that current medications are Celebrex, Ketoprofen cream, Lyrica, Mobic, Naprosyn, Pennsaid and sulindac. On physical examination there is tenderness to the patella, lateral facet of patella. There is localized swelling present. There is no effusion and no mass present. Range of motion is full and painless. There is no crepitus on range of motion. McMurray testing is negative. There is no weakness present. Progress note dated 10/20/14 indicates that physical examination is unchanged. The note states that he does not have severe osteoarthritis. He is not a candidate for total knee replacement.

Initial request for Synvisc injection was non-certified on 08/21/14 noting that there is no indication that the patient has significant symptomatic osteoarthritis. The denial was upheld on appeal dated 10/08/14 noting that there is no documentation of severe osteoarthritis. The referenced guidelines do not recommend injections for chondromalacia patellae, facet joint arthropathy, osteochondritis dissecans, patellofemoral arthritis or patellofemoral syndrome.

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 has completed treatment in the form of physical therapy, medication management and cortisone injections. The MRI of the right knee is essentially normal. There is no documentation of significantly symptomatic osteoarthritis. The Official Disability Guidelines would support Synvisc injections for patients who 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. The Official Disability Guidelines report that 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. As such, it is the opinion of the reviewer that the request for synvisc injection to the right knee is not recommended as medically necessary and the prior denials are upheld.

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)