

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 1, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L) knee injection and gel one CPT Code(s): 20610, J7326, J3490, J3301x4

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

This physician is Board Certified in Orthopedic Surgery with over 40 years of experience.

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. No mechanism of injury was provided.

On March 13, 2014, the claimant presented to PA 6 to 8 weeks status post left knee partial medial meniscectomy. He was doing better but still complained of pain to his medial joint line. He was able to return to all activities at work. Medications included Aspirin 81 mg, Cheratussin AC as needed, Dalmane 30 mg as needed, Diovan, Lopressor, Plavix. On examination he was tender to palpation in the medial joint line. He had full range of motion. There was no effusion noted. Strength was 5/5 for his quadriceps and hamstrings. He had a stable ligament exam to varus and valgus to 30 degrees and a negative Lachman's test. Plan: He was provided a prescription for Celebrex.

On May 29, 2014, the claimant presented with continued complaints of some pain over the medial joint line. It was noted that on arthroscopy there was some chondromalacia to the medial compartment. On physical examination there was slight tenderness to palpation over the medial joint line. Trace palpable effusion. Full range of motion, 4+/5 strength to quadriceps and hamstrings. Plan: Continue physical therapy, working on correcting his strength deficits. Also it was recommended to proceed with a corticosteroid and Visco supplementation injection to try to get the pain in his knee to calm down.

On June 23, 2014,. Rationale for Denial: This patient has no objectively identifiable knee pathology that would reasonably necessitate or benefit from either visco supplementation or a steroid injection. ODGH criteria for either injection are not met.

On July 1, 2014, UR. Rationale for Denial: The prior adverse determination was reviewed stating that the patient has no objective identifiable knee pathology that would necessitate Visco supplementation or steroid injection. In the context of this request, no additional medical records have been provided. ODG states that steroid injections result in significant reduction in osteoarthritic knee pain. The submitted CPT codes include 20610 Aspiration, joint, major J7326: Hyaluronan or derivative, gel-one, for intra-articular injection, perse J3490 (Unclassified Drugs) J3301 Injection, triameinolone acetone, not otherwise specified. Wight-bearing views showed no significant arthritis. ODG states that Visco supplementation can be recommended for significantly symptomatic arthritis that has not been demonstrated here.

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

The previous adverse determinations are upheld. The request for Visco supplementation or steroid injection does not meet ODG criteria. There is no documentation of symptomatic severe osteoarthritis, which would include bony enlargement, bony tenderness, crepitus on active ROM, less than 30 minutes of morning stiffness and no palpable warmth of synovium. Therefore, the request for L) knee injection and gel one CPT Code(s): 20610, J7326, J3490, J3301x4 is not found to be medically necessary at this time.

PER ODG:

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.

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, which may include the following: Bony enlargement; Bony tenderness; Crepitus (noisy, grating sound) on active motion; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Over 50 years of age.
- 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)**