

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/07/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** left knee supartz injections, series of 5

**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 left knee Supartz injections, series of 5 is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell off a dock. MRI of the left knee dated 10/09/14 revealed a moderate complex branching grade 3 tear seen involving the posterior horn body aspects of the medial meniscus; minimal horizontal closed tear and less likely a grade 3 tear of the posterior horn of the lateral meniscus; no significant ligament tears of the left knee; mild tricompartmental degenerative disc disease. The patient underwent left knee arthroscopy with partial medial and partial lateral meniscectomy on 12/16/14. Office visit note dated 01/07/15 indicates that he is still ambulating with crutches. He has been working in physical therapy and has full extension and flexion about 100 degrees. The patient completed 12 postoperative physical therapy visits. The patient underwent steroid injection to the left knee on 02/02/15. Functional capacity evaluation dated 03/19/15 indicates that the patient underwent arthroscopic surgery to repair his meniscus on 12/16/14. He reported that he does not think the surgery helped and he still has pain in the knee. It is reported that there are some inconsistencies in his self-reported function and his actual function. The patient was recommended to continue physical therapy.

Initial request for series of 5 Supartz injections to the left knee was non-certified on 01/15/15 noting that the patient is documented as not having started post-op PT. The request for this injection is to help the patient get to baseline quicker. There is absolutely no evidence that a Supartz injection is capable of "getting the patient to baseline quicker" after knee arthroscopy. The denial was upheld on appeal dated 02/13/15 noting that the documentation submitted failed to provide evidence of significant functional deficit in the patient. It was also indicated that the patient participated in physical therapy and was taking non-steroidal anti-inflammatory medications; however, the documentation failed to provide evidence of failure of these conservative therapies.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries to the left knee on 09/29/14 and was subsequently treated with left knee arthroscopy on 12/16/14 followed by postoperative physical therapy and steroid injection on 02/02/15. The submitted functional capacity evaluation indicates that there are some inconsistencies in his self-reported function and his actual function. He was able to balance for 10 seconds on his left leg with no pain but reports that he cannot put all his weight on the leg when climbing stairs or ladder. On self-report, he stated that he could only lift very light weight, but reported no issues with the 50 lb box. There are no postoperative imaging studies/radiographic reports submitted for review. Additionally, the Official Disability Guidelines state that the routine use of hyaluronic acid after knee arthroscopy cannot be recommended. As such, it is the opinion of the reviewer that the request for left knee Supartz injections, series of 5 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)