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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left Knee Synvisc One Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Orthopedic Surgeon with over 13 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 sustained injury to his left knee on XX/XX/XX. He was diagnosed with medial meniscal tear. A request was made for left knee Synvisc One Injection.

XX/XX/XX: Office visit. PE: Tenderness over the medial joint and predominantly to some degree over the pateliofermoral joint. Crepitus is noted on range of motion lacking full extension 5 degrees and flexion 135 degrees with pain on terminal flexion. **Impression:** Post meniscectomy syndrome. The claimant is a candidate for viscosupplementation.

XX/XX/XX: Office visit. Claimant has been having constant sharp pain 7/10 as he is walking he feels like something is going to pop. Claimant is still taking Advil, Cyclobenzaprine and Naproxen.

XX/XX/XX: MRI left knee. 1. An oblique tear through the body of the meniscus is seen communicating with the tibial surface. The posterior root is intact. No acute tear of the leteral meniscus is seen. 2. A mild joint effusion is present. 3. No acute ligamentous strain or tear is seen. 4. The femotibial and patellofemoral joint are unreasonable. No focal _____ cartilage or chondromalicaia is noted. No subchrondral edema is seen.

XX/XX/XX: Office visit. The claimant sustained an injury as a security guard. He was opening up the roof/coming down a ladder, missed and twisted his knee. He also contused his knee as he fell onto the ladder. He had sudden onset of pain and discomfort. He noticed swelling and pain. Claimant reported that the pain has been predominantly over the medial aspect of the knee since onset. The swelling has gone down. The bruising has diminished, but he is still painful in certain maneuvers. Most of that has to do with loading and twisting. In the interim, he had PT and course of six visits. Continued treatment including PT and medications did not allow complete resolution of his symptoms. He has had a sense of locking and catching in the medial aspect of the

knee. Prolonged standing and twisting could induce his pain. As such, an MRI was obtained which showed a medial meniscal tear. **PE:** Claimant has a slight limp. Slight swelling noted as the knee. Full extension. Flexion 135 with pain in terminal flexion. Tenderness over the medial joint line is reproducible. Positive McMurray's, negative Lachman's.

XX/XX/XX: Office visit. Claimant present with follow up for a left knee injury. Claimant has had left meniscus repair. Claimant states he feels better but still has pain in medial side of his left knee. Claimant states that therapy has helped. Pain 3/10. **PE:** Swelling and Sx portal scars present, but no deformity. No ecchymosis and no erythema. Tenderness. Diffuse lateral knee and diffuse medial knee. ROM: limited ROM in all planes and painful in all planes. Neuro/Vascular neurovascular function intact. **Assessment:** Post medial meniscus repair. No medications were prescribed.

XX/XX/XX: Office visit. **Medications:** Acetaminophen, celecoxib 200mg, cyclobenzaprine 10mg, hydrocodone 7.5mg, ibuprofen 800mg, lisinopril 10mg, metoprolol tartrate 25mg, naproxen 500mg. Claimant reported pain 3/10. Does see some modest improvement. Overall, still requires pain medications. However, he would like to return back to work to some type of modified duty and see if his company will accommodate. **PE:** Still reveals about 10 degrees of extension loss, 95 degrees of flexion. He has no mid flexion instability, still 2+ edema presents to the right lower extremity compared to 0 on the left. He seemed to have recurrence of some of the lymphedema to the right lower extremity. The knee itself is nontender to palpitation. He has a well-healed surgical incision midline.

XX/XX/XX: Office visit. Examination show some quadriceps atrophy at least 2 ½ to 3 cm when compared to the contralateral side. He is able to full extend the knee, but has weakness on active resisted extension. Flexion is unremarkable. He is point tender on palpation across the medial joint line. McMurray's is _____. No effusion is present today. No gross ligament instability is noted. **Plan:** Although he has had 12 formal sessions of PT for the meniscus tear, he still has fairly significant atrophy present to the left quadriceps and VMO.

XX/XX/XX: Follow up: Claimant continues to have discomfort about the knee. This is despite PT. Although, he has gained that ROM and the strength, he is still having the same discomfort. He attributed this back to some early sessions with exercises refilled. A sharp stabbing pain to the knee, since that time it has never completely resolved. He states that although it is not significantly worse, it is still not improving and this is already several months out from his surgery. **PE:** Claimant has point tenderness to palpation across the medial joint line. He has still positive McMurray's sign with pain reproduction across the medial joint. Full active ROM. Some mild quadriceps atrophy as well as the VMO. Will request a new MRI.

XX/XX/XX: Office visit. **Medications:** Acetaminophen, celecoxib 200mg, cyclobenzaprine 10mg, hydrocodone 7.5mg, ibuprofen 800mg, lisinopril 10mg, metoprolol tartrate 25mg, naproxen 500mg. **X-ray:** mild medial joint space narrowing is present without osteophytes or evidence of AVN. Slight tibial varum is noted. Negative for fractures. **Assessment:** 1. Tear of medial meniscus of knee. 2. Discuse muscle atrophy.

XX/XX/XX: Designated Doctor Examination. **Knee ROM:** Flexion right: 130 degrees, Right 120 degrees. Extension: right 0, left 0. Upon review of all records received and the designated doctor examination of XX/XX/XX, it is my professional and medical opinion that Maximum Medical Improvement occurred on XX/XX/XX.

XX/XX/XX: MRI left knee W/WO contrast. **Impression:** left knee MRI with contrast demonstrates postsurgical changes of partial medial meniscectomy with no evidence of recurrent tear. With increased signal within the meniscus body and posterior horn are likely residual myxoid change. Increased signal and fraying of the distal aspect of the anterior cruciate ligament with no tear, possible related to previous partial thickness injury. Lateral Meniscus and knee ligaments are otherwise intact. Grade 2 patellofemoral chondromalacia with no high-grade or full-thickness chondral lesions. No bone contusion or acute fracture. Trace joint effusion.

XX/XX/XX: Office visit. Claimant received Corticosteroid injection.

XX/XX/XX: Office visit. Claimant was seen for follow up. Reported steroid injection did not provide any relief. Claimant reported 6/10 pain level. He maintains 0 to 120 degrees of active ROM with increased pain on deep flexion of the knee without any ligament instability present.

XX/XX/XX: UR. Rationale for denial: The patient is a male who sustained an injury to his left knee on XX/XX/XX. He was diagnosed with medial meniscal tear. There was no indication that the patient has received a recent course of adequate conservative treatment including skilled therapy. There was patellofemoral crepitus particularly with loading of the inferior pole of the patellofemoral joint on examination. Based on these points, the medial necessity of this request is not established.

XX/XX/XX: Office visit. **Medications:** Acetaminophen, celecoxib 200mg, cyclobenzaprine 10mg, hydrocodone 7.5mg, ibuprofen 800mg, lisinopril 10mg, metoprolol tartrate 25mg, naproxen 500mg. **PE:** Examination shows tenderness over the medial joint and predominantly to some degree over the patellofemoral joint. Crepitus is noted on ROM lacking full extension 5 degrees and flexion 135 degrees with pain on terminal flexion.

XX/XX/XX: Office. PE: **Medications:** Acetaminophen, celecoxib 200mg, cyclobenzaprine 10mg, hydrocodone 7.5mg, ibuprofen 800mg, lisinopril 10mg, metoprolol tartrate 25mg, naproxen 500mg. **PE:** Examination shows tenderness over the medial joint and predominantly to some degree over the patellofemoral joint. Crepitus is noted on ROM lacking full extension 5 degrees and flexion 135 degrees with pain on terminal flexion.

XX/XX/XX: UR. Rationale for denial: The patient is a male who sustained a fall injury to his left knee on XX/XX/XX. He was diagnosed with meniscectomy syndrome. An appeal was make for left knee Synvisc one Injection. The previous request was denied because there was no indication that the patient has received a recent course of adequate conservative treatment including skilled therapy and there was patellofemoral crepitus particularly with loading of the inferior pole of the patellofemoral joint on examination. Treatments to date include activity modification, PT, corticosteroid injection and pain medication. Crepitus was noted on ROM that lacked 5 degrees in full extension, and 135degrees flexion. The patient reported pain predominantly affecting eh patellofemoral joint. There was patellofemoral crepitus particularly with loading of the inferior pole of the patellofemoral joint on examination. Given these issues, the medical necessity of the request is not established and the previous determination is non-certified.

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

The request for a Synvisc One injection is denied.
The Official Disability Guidelines (ODG) supports hyaluronic acid injections in patients with symptomatic osteoarthritis who have failed conservative treatment. The ideal candidate for these injections should have symptomatic severe osteoarthritis of the knee. The pain associated with the osteoarthritis should interfere with functional activities. These injections can be considered in patients who have failed cortisone injections. The ODG does not support these injections for patellofemoral osteoarthritis or chondromalacia patellae.

This patient is currently dealing with knee pain following a partial meniscectomy of the medial meniscus. His recent MRI demonstrates no evidence of recurrent meniscal tear. He has mild (grade II) osteoarthritis of the patellofemoral joint. The location and low-grade nature of the osteoarthritis do no meet the ODG criteria for hyaluronic acid injections.

The requested injection is not medically necessary for this patient.
ODG Guidelines:

Synvisc is a brand of hylan supplied by Genzyme Corporation. See Hyaluronic acid injections, where a series of three injections of Hylan or one of Synvisc-One hylan are recommended as an option for osteoarthritis.

Criteria for Hyaluronic acid injections:
(1) Patients experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative non-pharmacologic (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;
(2) 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; Over 50 years of age.
(3) Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease;
(4) Failure to adequately respond to aspiration and injection of intra-articular corticosteroids;
(5) Generally performed without fluoroscopic or ultrasound guidance;
(6) 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)
(7) 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.
(8) Hyaluronic acid injections are NOT recommended for any other indications such as chondromalacia patellae, facet joint arthropathy, osteochondritis dissecans, 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, or temporomandibular joint) since 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)**