

## Notice of Independent Review Decision

**Date of Review:**                      08/16/08

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Manipulation of right knee joint with lysis of adhesions under general anesthesia

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

Certified by The American Board of Orthopaedic 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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Service Units	Upheld/ Overturned
		Prospective	718.56	27570	1	Overturned

**Notice of Independent Review Decision**  
**Page 2**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Denial letter dated 6/24/08  
Pre-Authorization review dated 6/24/08  
Denial letter dated 6/26/08  
Reconsideration review dated 6/26/08  
Denial letter dated 7/18/08  
Appeal Review dated 7/17/08  
Correspondence throughout appeal process  
Request for a Review by an Independent Review Organization dated 8/5/08  
Operative report of 9/28/06  
H&P dated 4/21/06  
Operative report of 4/21/06  
Rehabilitation Referral form  
Physical therapy notes 10/23/06, 11/8/06, 11/9/06, 11/14/06, 11/15/06, 11/17/06,  
11/21/06, 11/22/06, 11/28/06, 11/29/06, 11/30/06, 12/5/06, 12/6/06, 12/12/06,  
6/20/08, 6/24/08, 6/25/08  
Medical notes dated 4/21/06, 9/11/06, 9/13/06, 10/3/06, 10/26/06, 11/16/06,  
12/14/06, 1/4/07, 1/18/07, 2/2/07, 2/23/07, 3/23/07, 4/13/07, 5/11/07, 5/25/07,  
6/19/07, 10/10/07, 10/31/07, 1/2/08, 5/7/08, 6/18/08, 7/30/08  
Medical notes dated 7/24/06, 8/31/06, 2/19/07  
MRI right knee dated 9/7/06  
MRI right knee dated 1/10/07  
Medical noted dated 3/18/08  
Letters dated 7/10/08, 7/30/08  
Case Management Report dated 6/20/07  
Letter dated 7/10/07  
EMG/Nerve Conduction Study dated 8/24/07

**PATIENT CLINICAL HISTORY:**

This male sustained a work-related injury to his right knee on xx/xx/xx. He has had ongoing right knee pain, and had arthroscopy surgery with partial medical meniscectomy in 9/2006. The patient had physical therapy but his knee pain persisted, and in 4/2008 he had a right total knee replacement. After the knee replacement surgery it appears that a total of approximately 15 sessions of physical therapy were authorized. The patient subsequently developed postoperative adhesions with decreased range of motion in his right knee as a complication of the knee replacement surgery. He has pain and stiffness in his right knee. The request for manipulation of the right knee under general anesthesia with lysis of adhesions was non-certified.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

In the Reviewer's opinion, manipulation of the right knee joint with lysis of adhesions under general anesthesia is medically necessary for this patient. The Reviewer explained that since the patient's right total knee replacement surgery in 4/2008, he now has only 85 degrees of flexion in his knee. The Reviewer noted that this lack of flexion clearly falls within the ODG criteria, which authorizes the requested manipulation for flexion less than 90 degrees. In the Reviewer's opinion this patient clearly has painful postoperative arthrofibrosis of his right knee, and the manipulation with lysis of adhesions should be authorized as soon as possible, as timeliness does matter in these cases for optimal patient results.

**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

**Notice of Independent Review Decision**  
**Page 4**

- 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)**