

# AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

**[Date notice sent to all parties]:** May 1, 2013

**IRO CASE #:**

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

Outpatient Right Knee MUA and Medial Meniscectomy with ACL repair (CPT code 29870)

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

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

## **REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male whom was injured on xx/xx/xx while working and slipped on the stairs and hurt his right knee and suffered a laceration. He was seen at a local ER and discharged with no fractures and received sutures to laceration.

xx-xx-xx: New Work Injury dictated by Provider. Noted left transverse suture to right knee. Assessment: right knee pain and right knee laceration after suture about 6 days ago. Management: 1. Keep wound clean, and we are just dressing him. 2. No prolonged standing or walking longer than 30%, so he should be sitting 70% of the time. Must use crutch 80%, must wear brace, no kneeling, squatting and no climbing on stairs or ladders. Return in 2 days for re-check. Naprosyn 500mg PO Q12hr PRN pain.

08-06-12: Progress Note. The claimant feels the pattern of symptoms is slowly improving. He has been working with duty restrictions and complains of swelling and discomfort. Assessment: Knee laceration, 891.0. Plan: Medications: change dressing twice daily, return for wound check in 3 days.

08-09-12: Injury Recheck dictated by Provider. Claimant stated he is unable to move right leg and is having a lot of pain at the right knee. PE: The right knee has a 10 cm concentric laceration at the distal aspect of the patella. There is some swelling in the knee and in the foot; 2+ distal pulses. He is unable to move knee either passively or actively, noted some joint laxity on lateral movement or the lower leg. Assessment: This is a right knee injury, laceration. Treatment Plan: MRI ordered due to joint laxity and confirm for knee either to the tendons or ligaments. Refer to orthopedics for reevaluation of the wound for surgical

debridement. Placed in knee brace and continue to use crutches and modified activity.

08-20-12: MRI of the Right Knee W/O contrast. Impression: 1. Soft tissue edema about the cut without MR criteria to suggest involvement of the joint. 2. Partial tear of the ACL. Approximately half the fibers remain intact. 3. Meniscal tear extends to the inferior articular surface of the posterior horn of the medial meniscus, seen only on the sagittal image slice #7 of the PD fat-saturated sequence. 4. Mild osteoarthritic changes in the apex of the femoral trochlea in the patellofemoral joint. 5. Grade I strain of the medial gastrocnemius and soleus muscle bellies. 6. office was notified of the above findings by fax with a follow-up phone call for confirmation of receipt.

08-21-12: Transcription. The claimant seen after MRI and does not have a patellar tendon tear. He is frustrated with ROM and infection; noted moderate swelling. He has severe atrophy of his quadriceps and very limited motion 10-30 degrees. Reviewing MRI noted soft tissue about the infrapatellar region but no joint involvement. He has positive partial 50% ACL tear and possible Meniscal tear. He has gastroc-soleus complex strain. Assessment: See MRI. Plan: Recommend getting him moving on with aggressive physical therapy, ROM and weight bearing as tolerated. Return for follow-up in 1 month, continue with light duty and stop using crutches.

09-18-12: Transcription. The claimant is still having difficulty with Rom and has severe atrophy from not moving his leg for so long. Ordered more PT and a home CPM machine to increase ROM. Re-evaluate in 3-4 weeks.

10-09-12: Transcription. The claimant is still experiencing pain and has moderate quad atrophy. He has active extension of -10 and has passive and active flexion now to 110 and passively another to 120. He needs probably 5 degrees of flexion actively and begin intensive strengthening over the next month. "He will be at MMI as I have told him today on return."

10-29-12: Therapy Discharge Note. The claimant reported Right knee pain and increases with activity and exercise. Objective: AROM of the R knee: 0-140 deg., MMT: gross: R Quads 4-/5, Hamstrings 4/5. Functional Status: increased step management to level 3 (8inches) today but with pain and difficulty.

10-30-12: Transcription. The claimant arrived still limping and having some moderate to severe amounts of pain; 8/10. Noted positive McMurray's medially. He is tender throughout the anterior aspect of the knee. He has active extension of -5 and flexion of 110. The claimant is 3 months post injury and as this point would recommend arthroscopic medial meniscectomy, evaluate ACL, and do a manipulation under anesthesia to make sure his knee gets full flexion and check his patellar tendon at that point, which had a negative laceration on MRI. Then rehab very aggressively for a month to be at MMI.

01-21-13: Office Visit. The claimant presented with right knee pain 6/10. Associated symptoms: swelling, stiffness, popping, weakness, and lower extremity pain. Assessment: Medial Meniscus tear 836.0, ACL tear 844.2. Right knee pain/tenderness: Claimant stated the pain is at peripatellar, medial joint line, and lateral joint line. ROM: flexion: 90, active extension: -20, passive extension: 0. Right knee stability: anterior drawer sign: positive, mild. McMurray Test: positive.

02-06-13: Progress Notes. Complaints of right knee pain 6/10 by claimant. Palpation of the knee reveals tenderness of the medial joint line and MCL, McMurray positive. Negative Lachmans and negative instability to varus and valgus stress. Assessment: 1. Knee internal derangement. 2. Healed knee laceration. Plan: request for surgery approval.

03-08-13: UR performed. Reason for denial: The claimant was noted to have difficulty with active full extension with severe pain. MRI performed on 08/20/2012 noted that he had a partial tear of the ACL, a meniscus tear that extended to the inferior articular soft surface at the posterior horn of the medial meniscus, mild arthritic changes in the apex of the femoral trochlea in the patellofemoral joint and a grade I strain of the medial gastrocnemius and soleus muscle bellies. The claimant was reported to continue with severe atrophy of his quadriceps and very limited range of motion and he was reported to be performing physical therapy and on 09/17/2012 the claimant was noted to have active range of motion of the right knee to 120 degrees and decreased strength of the right quadriceps and hamstrings at 4-/5. He continued to have pain and was noted to continue to have moderate to severe atrophy and weakness at the quadriceps and severely decreased active range of motion of the right knee and decreased passive extension of the right knee. The ODG recommend a diagnostic arthroscopy after failure of conservative care with medications and/or physical therapy with continued subjective complaints of pain and functional limitations despite conservative care and when imaging studies are inconclusive, and manipulation under anesthesia is noted to be under study for treatment of arthrofibrosis, or after a total knee arthroplasty for patients that fail to achieve greater than 90 degrees flexion after 6 weeks can be considered candidates for manipulation under anesthesia. As the claimant is not noted to have inconclusive findings on MRI, which showed a partial ACL tear, a Meniscal tear extending to the articular surface of the posterior horn of the medial meniscus and a grade I strain of the medial gastrocnemius and soleus muscle bellies and mild arthritic changes of the trochlear groove. The request for diagnostic arthroscopy does not meet guideline recommendations. It is noted that he underwent 23 sessions of physical therapy with improvement of range of motion, but following the discharge from physical therapy the claimant's range of motion decreased severely again and he is noted now to have flexion of less than 80 degrees and extension of -5 to 9 is 10 degrees. As such, the request for a manipulation under anesthesia cannot be authorized. Based on the above, the request for an outpatient right knee diagnostic arthroscopy and joint manipulation under anesthesia 29870 in non-certified.

03-12-13: UR performed. Reason for denial: The claimant was not reported to complain of joint pain and swelling. The claimant is noted to have a limited range of motion, but is no less than 90 degrees of flexion, and he is not noted to have a positive Lachman's or Pivot Shift. As such, the request for an appeal outpatient right knee MUA and medial meniscectomy with ACL repair 29870 is non-certified.

03-14-13: Office Visit dictated. The claimant presented with pain localized in the right patella and continues to have pain and limited ROM. He is doing HEP. Assessment: Claimant describes his pain as sharp and severe, continuous. Pain is increased with activity and weight bearing. Pain interferes with activities of daily living and rated at 10/10. His symptoms are worse when bending, twisting, moving, walking, and standing. PE: Right knee: pain reported at the medial joint line. ROM: flexion: 60 active extension, -10 passive extension: full. Quadriceps strength and tone: significant atrophy.

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

The previous adverse decisions are partially overturned. MRI dated 8/20/12 showed a meniscal tear extends to the inferior articular surface of the posterior horn of the medial meniscus, seen only on the sagittal image slice #7 of the PD fat-saturated sequence. The MRI also showed a partial ACL tear and grade I strain of the medial gastrocnemius and soleus muscle bellies and mild arthritic changes of the trochlear groove. noted on during his examination on 01/21/13 that the claimant presented with right knee pain 6/10 with symptoms of swelling, stiffness, popping, weakness, and lower extremity pain. On physical examination he had flexion of 90 degrees and -20 degrees of extension with a positive anterior drawer sign. On 03/14/13 noted the claimant presented with pain that interferes with activities of daily living and rated at 10/10. The claimant's ROM was reported to be decreased to 60 degrees of flexion with -10 degrees of extension and he had significant quadriceps atrophy. noted on her examination from 02/06/13 that the claimant had tenderness along the medial joint line and MCL and had a positive McMurray sign. She also noted there was Negative Lachman's and negative instability to varus and valgus stress. The medical records documented the claimant has completed 23 sessions of physical therapy but continues to have complaints of pain rate 10/10 and restricted ROM.

According to ODG Indications for Meniscectomy, the claimant meets all criteria as he has completed PT, has joint pain and swelling, documented findings of positive McMurray's sign, joint line tenderness, and limited ROM, and MRI findings. The claimant does not meet the ODG Indications for ACL surgery as there was no instability of the knee, no positive Lachman's sign and no positive Pivot Shift. According to ODG manipulation under anesthesia is noted to be under study for treatment of arthrofibrosis, or after a total knee arthroplasty. As the claimant is not under treatment for either, this request would not meet ODG guidelines. Therefore, the request for Medial Meniscectomy meets ODG guidelines and would be medically necessary at this time; however, the OP Right Knee MUA and ACL Repair do not meet ODG guidelines and are not medically substantiated at this time.

Per ODG:

<p>Meniscectomy</p>	<p><b><u>ODG Indications for Surgery</u> -- Meniscectomy:</b>  <b>Criteria</b> for meniscectomy or meniscus repair (Suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positive). Physiologically younger and more active patients with traumatic injuries and mechanical symptoms (locking, blocking, catching, etc.) should undergo arthroscopy without PT.  <b>1. Conservative Care:</b> (Not required for locked/blocked knee.) Exercise/Physical therapy (supervised PT and/or home rehab exercises, if compliance is adequate). AND ( Medication. OR Activity modification [eg, crutches and/or immobilizer].) PLUS  <b>2. Subjective Clinical Findings (at least two):</b> Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS  <b>3. Objective Clinical Findings (at least two):</b> Positive McMurray's sign. OR Joint line tenderness. OR Effusion. OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS  <b>4. Imaging Clinical Findings:</b> (Not required for locked/blocked knee.) Meniscal tear on MRI (order MRI only after above criteria are met). (<a href="#">Washington, 2003</a>)  For average hospital LOS if criteria are met, see <a href="#">Hospital length of stay</a> (LOS).</p>
<p>Anterior cruciate ligament (ACL) reconstruction</p>	<p><b><u>ODG Indications for Surgery</u> -- Anterior cruciate ligament (ACL) reconstruction:</b>  <b>1. Conservative Care:</b> (This step not required for acute injury with hemarthrosis.) Physical therapy. OR Brace. PLUS  <b>2. Subjective Clinical Findings:</b> Pain alone is not an indication for surgery. Instability of the knee, described as "buckling or give way". OR Significant effusion at the time of injury. OR Description of injury indicates rotary twisting or hyperextension incident. PLUS  <b>3. Objective Clinical Findings (in order of preference):</b> Positive <a href="#">Lachman's sign</a>. OR Positive <a href="#">pivot shift</a>. OR (<i>optional</i>) Positive <a href="#">KT 1000</a> (&gt;3-5 mm = +1, &gt;5-7 mm = +2, &gt;7 mm = +3). PLUS  <b>4. Imaging Clinical Findings:</b> (Not required if acute effusion, hemarthrosis, and instability; or documented history of effusion, hemarthrosis, and instability.) Required for ACL disruption on: Magnetic resonance imaging (MRI). OR Arthroscopy OR Arthrogram.  (<a href="#">Washington, 2003</a>) (<a href="#">Woo, 2000</a>) (<a href="#">Shelbourne, 2000</a>) (<a href="#">Millett, 2004</a>)  For average hospital LOS if criteria are met, see <a href="#">Hospital length of stay</a> (LOS).</p>
<p>Manipulation under anesthesia (MUA)</p>	<p>Under study as a treatment of arthrofibrosis (an inflammatory condition that causes decreased motion) and/or after total knee arthroplasty. Following total knee arthroplasty, some patients who fail to achieve &gt;90 degrees of flexion in the early perioperative period, or after six weeks, may be considered candidates for manipulation of the knee under anesthesia. (<a href="#">Namba, 2007</a>) (<a href="#">Magit, 2007</a>) (<a href="#">Keating, 2007</a>) (<a href="#">Pariente, 2006</a>) (<a href="#">Esler, 1999</a>) This study advocates that MUA should be used for stiff knee arthroplasties after failed physical therapy. (<a href="#">Mohammed, 2009</a>) This study concluded that MUA is a valuable technique to increase ROM after TKA (total knees) in patients with stiff knees, for revision-knees and all other patients with reduced flexion after different forms of intra-articular knee surgical procedures. The results were similar for early and delayed MUA relative to the last surgery, so patients can undergo conservative treatment (e.g. physical therapy) before the MUA without risk of poorer outcome. The results after MUA in patients with many previous operations were significantly worse, so an open/arthroscopic arthrolysis should be discussed earlier for this subgroup. (<a href="#">Ipach, 2011</a>) According to this study, if all methods of PT treatment have been exhausted trying to develop ROM after TKA, manipulation under anaesthesia (MUA) may be considered. (<a href="#">Ipach2, 2011</a>)</p>

	<p>Ruptured pseudoaneurysm should be included in the differential diagnosis whenever a patient presents with pain and swelling of the thigh after MUA. (<a href="#">Sambaziotis, 2011</a>) Most patients experience improvements in ROM from MUA after TKA, but patients with diabetes are at risk for lower final ROM after MUA. Manipulation within 75 days of TKA is associated with better ROM. (<a href="#">Bawa, 2012</a>) Orthopedic surgeons, not chiropractors, should perform this. See also the <a href="#">Low Back Chapter</a>, where MUA is not recommended in the absence of vertebral fracture or dislocation.</p>
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**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)**