AccuReview

An Independent Review Organization
569 TM West Parkway
West, TX 76691
Phone (254) 640-1738
Fax (888) 492-8305

Notice of Independent Review Decision

[Date notice sent to all parties]: November 3, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Repeat Left Knee Manipulation Under Anesthesia 27570

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

This physician is Board Certified in Orthopaedic Surgery with over 15 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 a work related injury on xx/xx/xx. He twisted his left knee. Surgery was performed in April 2011. It appears he had partial meniscectomy, chondroplasty, and plica resection.

07-14-11: Orthopedic Note. CC: left knee main, continued swelling and pain, denying radicular symptoms. PE: On exam, the left knee ROM is 0 to about 100 degrees. There is mild effusion. There is no varus or valgus laxity and has good end point of Lachman exam. Some tenderness noted over the medial aspect of the knee as well as anteromedially. He had mild antalgic gait. Imaging: Two views of the left knee reported no fracture or any bony lesion. MRI: previous MRI before surgery showed some medial compartment degenerative changes as well as a medial meniscus tear. Impression: 1. Left knee pain after arthroscopy. 2. Questionable left knee synovitis. Plan: The claimant is still having discomfort. Request that he bring the op report for review as it is unsure exactly what was

preformed and what was found at time of surgery. Request precertification for aspiration and intraarticular steroid injection to hopefully calm down the inflammatory process. He is at regular work activity and has already reached MMI. Follow up in a couple of weeks after retrieving the information that has been requested.

07-28-11: Orthopedic Note. Claimant presented with continued pain at the patellofemoral joint, specifically when going down stairs. He has an effusion. PE: On exam of the knee, his ROM is 0 to about 100 degrees. There is an effusion and obvious crepitus at patellofemoral joint. He had mild antalgic gait. Procedure: 15cc of straw colored fluid was aspirated from the knee followed by injection of 4 cc of Marcaine, 4 cc of Xylocaine, and 2 cc of Depo-Medrol, and he did get some good relief. Impression: 1. Left knee chondromalacia. 2. Left knee synovitis. Plan: Explained that most of his pain is coming from the chondromalacia of the patellofemoral joint, and recommend he follow up with his PCP and follow up with me as needed after his injection as he is already at MMI and back to regular work activity.

07-29-11: Physician Activity Status Report. Patient Status: Regular Activity – Referred, but returning for follow-up visit. Return to regular duty on 07/29/2011.

09-15-11: Progress Note. Claimant complained of limping at work and has associated right hip pain. PE: exam deferred. Assessment: 1. Meniscus tear, 836.2. 2. S/p partial medial meniscectomy, chondroplasty, synovectomy and plicectomy of left knee. 3. Chondromalacia. Plan: refer for impairment rating. Prescriptions: Ultram 50 mg po Q6hrs PRN moderate to severe pain #30, Norco 5/325 1 po q 6hr prn pain #30. Work restrictions: no standing/walking longer than tolerated, no lifting over 30lbs, no push/pull over 50lbs, no kneeling/squatting. Follow up in 10 days.

09-15-11: Physician Activity Status Report. Patient Status: Modified Activity – Returning for follow-up visit. Restricted Activity (in effect until next physician visit): Return to work on 09/15/2011 with the following restrictions: no lifting over 30 lbs., no prolonged standing and/or walking longer than tolerated, no pushing and/or pulling over 50 lbs of force, no squatting and/or kneeling.

09-26-11: Physician Activity Status Report. Patient Status: Modified Activity – Returning for follow-up visit. Restricted Activity (in effect until next physician visit): Return to work on 09/26/2011 with the following restrictions: no lifting over 30 lbs., no prolonged standing and/or walking longer than tolerated, no pushing and/or pulling over 50 lbs of force, no squatting and/or kneeling.

10-07-11: History and Physical. CC: left knee pain. PE: Musculoskeletal: Left knee- the claimant walked with a limp favoring the left knee, no effusion present. There is mild medial and lateral joint line pain and patellar pain on compression. Noted full flexion of left knee, but extension of knee to only approximately 90%. Impression: Left knee internal derangement-postsurgical-with continued pain. Plan: Refer to orthopedic surgeon for consultation and also to a pain

management specialist. Follow up after consultation is complete one month or prn, Form 73 complete with restrictions.

12-01-11: Post-Arthrographic MRI Left Knee. Impression: 1. A small posteromedial horn meniscal tear with margins intersecting inferior and posteromedial meniscus aspects from appearance, this would reflect an arthroscopically repaired tear or recurrent tear. 2. Mild degree thickening and blunting of the posteromedial meniscus in the region of the intercondylar notch, consistent with injury but no tear identified.

08-16-12: MRI of the Left Knee, Post Arthrogram. Impression: 1. Medial meniscus probable partial meniscectomy change. Correlate with the surgical history. Complex posterior horn morphological appearance, with suspected tearing of the remnant. 2. Prominent fibrosis most at the infrapatellar fat body. 3. Atypical joint fluid appearance, which is not characteristic for arthrogram fluid or a native effusion. 4. Mild osteoarthrosis. 5. Retrograde 3 chondromalacia. 6. No cruciate or collateral ligament tear.

03-22-13: Designated Doctor Evaluation. Compensable Injury: Left knee sprain/strain, left knee meniscus tear. PE: Left Knee: There is medial and lateral joint line tenderness noted on palpation. There are three well healed surgical portals noted about the anterior left knee joint. Valgus stress is negative and Varus stress test reveals mild ligamentous laxity. There is mild joint crepitation noted with active and passive motion. Knee ROM Testing: Flexion: R 120 degrees, L 110 degrees; Extension: R 0, L 0; Valgus deformity and Varus deformity negative left and right. Impression: V45.89 S/P Left knee arthroscopy, 717.9 Internal derangement left knee. MMI: The claimant has received the recommended course of therapy for the accepted compensable injury as outlined in the ODG guidelines. Although the records indicate that future medical intervention may be pending, the claimant reached statutory MMI as of January 29, 2013. Impairment rating: The claimant demonstrated a decrease in AROM of the left knee when compared to the right. However, the demonstrated ROM value is within the normative range and qualifies for 0% whole person impairment based on Table 41 of the AMA Guides. The claimant has had partial medial and lateral meniscectomy. According to Table 64 of the AMA Guides, the claimant qualifies for 10% LEI. The claimant also has mild collateral ligament laxity and qualifies for 7% LEI. The combined value is 16% LEI; which converts to 6% whole person impairment. The total impairment is 6% whole person.

12-03-13: Operative Report. Preoperative Diagnosis: Left knee end-stage posttraumatic chondromalacia. Operation: Left total knee replacement. Postoperative Diagnosis: Left knee end-stage posttraumatic chondromalacia.

01-13-14: Follow Up. CC: left knee pain-postoperative. PE: left knee- there is a vertical scar with moderate edema over the knee. There is generalized tenderness over the left knee and he walks with a limp and with a cane. Impression: Left knee internal derangement-postoperative. Plan: Continue PT which is being administered at home; continue to see the pain management

doctor to control discomfort. Continue to use cane and follow-up with surgeon at scheduled times. Form 73 completed: sedentary work only with no lifting or prolonged walking. F/U one month.

01-21-14: Physical Performance Evaluation. Current job description: Lift category: Heavy work. Assessment: The claimant is unable to perform their regular job duties at this time. Recommendations: 1. psychological evaluation for claimant's emotional complications as a result of their injury and the surrounding problems being off work or work restrictions which includes but not limited to the possibility of depression and lack of self worth. 2. Any referrals the treating doctor feels is necessary. 3. Claimant would benefit from a post surgical active therapy program. 4. Claimant can benefit from condition in post surgical active therapy to increase strength, ROM as well as increase function. 5. According to the objective findings, the claimant does not meet the requirements, safety, and performance ability to do their job safely, effectively, and confidently (without restrictions). The claimant is not capable of performing their job duties (without restrictions) until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment.

01-29-14: Workers Comp OV. CC: F/U left knee-PT. Constitutional: doing HEP; has not started outpatient PT yet. PE: Left knee: inspection: trace effusion, diffuse soft tissue swelling, healed scar present. Palpation: diffuse medial tenderness present, diffuse lateral tenderness present. ROM: AROM 5-100. Assessment: 1. Internal derangement of knee NOS 717.9, 2. Chondromalacia of patella 717.7, 3. Sprain of knee NOS 844.9, 4. Effusion of joint of lower leg 719.06. Plan: Start outpatient PT ASAP. F/U 9 weeks.

03-12-14: Follow Up. CC: left knee pain-postoperative. PE: left knee: there is moderate edema surrounding the knee but good range of motion. Impression: Internal derangement left knee-postoperative. Plan: Continue to follow up with his surgeon. Recommend 12 more sessions of physical therapy at the request of his surgeon. Form 73 completed: modified work with no prolonged walking or standing. F/U in one month.

05-27-14: Health and Behavioral Reassessment. Diagnosis: 300.82 Somatic Symptom Disorder, with predominant pain, persistent, mild. Secondary problem areas identified that are impacting his recovery include: Based on the information gathered through the initial interview with our offices and the claimant's emotional presentation and verbal report, we would determine that the work accident pain and ensuring functional limitations have caused the claimant's disruption in lifestyle, leading to poor coping and maladjustment and disturbances in sleep and mood. The claimant appears to have been functionally independently prior to the work injury of xx/xx/xx. Treatment goals and objectives for identified deficit areas: Recommend that the claimant continue a CPMP as he has exhausted conservative treatment of physical therapy, injections, yet continues to struggle with pain and functional problems that pose difficulty to his performance of routine demands of living and occupational functioning. FABQ was positive for fear and avoidance of physical activity in general (FABQ-PA=16). The claimant also

endorsed a high level of frustration with his overall quality of sleep. Thus, it is recommended that he be approved for continuation in the CPMP in order to increase his physical and functional tolerances and to facilitate a safe and successful return to work.

06-04-14: Workers Comp OV. CC: F/U S/P left TKR 12/2013. Claimant completed post op physical therapy and stated he is getting stiff despite doing HEP. Medications: Naprosyn, hydrocodone, Ambien, pravastatin, Aspirin. PE: Left knee: trace effusion and diffuse soft tissue swelling noted. On palpation, diffuse medial tenderness present, diffuse lateral tenderness. ROM: AROM 0-70 then mechanical block. Assessment: 1. Sprain of knee NOS 844.9, 2. Tear Med Menisc knee-cur 836.0. Plan: Claimant's motion is getting worse despite exercising; has had significant PT; recommend MUA.

07-08-14: Operative Report. Operation: Left knee manipulation under anesthesia. Preoperative Diagnosis: Left knee stiffness, status post total knee replacement. Postoperative Diagnosis: Left knee stiffness, status post total knee replacement.

07-17-14: Initial Rehab Evaluation. CC: Total knee replacement, post, MUA. Medications: Norco 10/325, Losartan potassium, Naproxen, Terazosin. Claimant rated degree of pain as constant in the left knee and reported numbness along the lateral aspect of the left knee, severity at 4/10. Activity tolerance: claimant reported symptoms aggravation and increased pain during activities involving lifting, bending, pushing, pulling and prolonged periods of sitting, walking, walking and carrying weight and driving. PE: Dermatomes: dermatomal patterns are showing increased sensitivity in the left L4 and L5 patterns. The left L5 pattern is especially sensitive at the lateral aspect of the knee. Postural exam: visual inspection revealed: a high left shoulder, left head tilt, slight head forward posture, high left hip. Gait analysis: slow, guarded gait with asymmetrical weight bearing favoring the left side on ambulation. Palpation: There is joint line tenderness along the left lateral aspect of the tibial plateau with mild heat and edema noted in palpation. There are taught and tender fibers and the left lateral collateral ligament. Crepitus is felt during the active motions of flexion and extension, along the lateral aspect of the left knee, extending above and below the joint line approximately two inches in both directions. ROM: flexion: 95 degrees, extension: -8 degrees. Motor: the motor strength in the left lower extremity is 4/5, and the right lower extremity is 5/5. Assessment: Left knee pain, TKR. Problems: pain, decreased strength, decreased AROM and decreased functional tolerance. Goals: Short-term: independent with HEP and normal mobility. Long-Term: strength increased by one grade throughout, perform all ADLs without pain. Plan: the claimant will be seen at this office for rehab therapy, initially consisting of an active care program with passive care performed on a PRN basis only. Recommendation: Chattanooga Intellect XT: to decrease pain and radicular symptoms while increasing function. Physical rehabilitation as stated below. Frequency/Duration 3 days x2 weeks.

08-08-14: Rehabilitation Progress Note. Subjective: Claimant continues to report improvement with therapy and rated pain as 4/10. Assessment: Claimant was able to tolerate the prescribed treatment. Plan: Continue with POC as tolerated by claimant. Perform re-evaluation at the completion of therapy. Changes to POC: Perform a re-evaluation and return claimant to treating doctor with a recommendation for further orthopedic consultation and possible treatment options.

08-21-14: Workers Comp OV. CC: F/U left knee PT. Claimant complained of pain and restricted ROM. PE: Left Knee: Inspection: antalgic gait, moderate effusion, diffuse soft tissue swelling; palpation: diffuse medial tenderness present, diffuse lateral tenderness present; ROM: active (in degrees): 0-80; Leg examination: calf soft and non-tender, NVI intact distally. Assessment: 1. Sprain of knee NOS 844.9, 2. Tear med menisci knee-cur 836.0. Plan: Claimant had MUA then no physical therapy for 3 weeks due to insurance issues. Also there was a 10 day delay in receiving post op CPM unit. Now his knee is locked up with AROM 0-80 degrees. Recommending repeat MUA with post op physical therapy set before procedure so there are no delays. Follow up: surgery – MUA left knee.

09-05-14: UR. Reason for denial: The claimant was noted to have manipulation under anesthesia to the left knee on 07/08/2014, with no physical therapy for 3 weeks due to insurance issues. Also, there was a 10-day delay in receiving postop CPM unit. Due to this delay, the claimant's knee was locked up with AROM of 0 to 80 degrees. The ODG Guidelines state manipulation under anesthesia of the knee should be attempted only after a trail (6 weeks or more) of conservative treatment (exercise, physical therapy and joint injections) have failed to restore ROM and relieve pain, and a single treatment session would then be recommended, not serial treatment sessions of the same bone/joint subsequently over a period of time. The documentation submitted for review indicated there was a delay in the claimant to receive the CPM device and beginning post-operative therapy. However, the claimant did ultimately begin therapy but this has not been provided for the recommended 6 week period of time per guideline recommendations to support the requested surgery. Therefore, in the absence of the attempt to proceed with conservative treatment, restore ROM, and relieve pain for at least 6 weeks, the request is not supported. Given the above, the request for OP repeat left knee manipulation under anesthesia 27570 is non-certified.

09-30-14: UR. Reason for denial: The claimant is a male who sustained an injury on xx/xx/xx (the mechanism of injury was not reflected in the submitted medical reports). The claimant is diagnosed with left knee arthrofibrosis. An appeal request if made for out-patient repeat left knee manipulation under anesthesia 27570. The previous request was denied because there was absence of the attempt to proceed with conservative treatment, restore range of motion, and relieve pain for at least six weeks. The claimant has history of left knee scope on 04/19/2011, 1/17/2012 and 10/09/2012. He had left knee replacement on 12/03/2013 and manipulation under anesthesia on 07/08/2014. Post-operatively, the claimant had Physical Therapy. The rehabilitation note dated 8/8/14 stated that the claimant has completed six visits and continued to improve.

The medical report dated 8/21/14 stated that the claimant has left knee pain and restricted range of motion. Medications include naproxen, hydrocodone, Ambien, pravastatin and aspirin. On physical examination of the left knee, there is antalgic gait, moderate effusion diffuse soft tissue swelling, diffuse medial tenderness present and diffuse lateral tenderness. Range of motion was noted to be 0 to 80 degrees. It was noted that the claimant had manipulation under anesthesia of the left knee then no PT for three weeks due to insurance issues. Also there was a ten day delay in receiving post operative CPM unit. An updated medical report addressing the issues of the previous determination was not submitted for review. Although the claimant has persistent left knee stiffness, exhaustion of recent Physical Therapy for at least six weeks was still not documented. In agreement with the pervious determination, the medical necessity of the request has not been established. There was no additional pertinent information provided on 09/29/2014. The case remains denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Previous adverse determinations are upheld and agreed upon. The claimant does not require a manipulation under anesthesia (MUA) based on the records reviewed. The claimant currently has 80 degrees of knee flexion following a previous MUA. The Official Disability Guidelines (ODG) recommends MUA following a knee replacement when the patient has less than 90 degrees of flexion. The claimant should complete a six course of physical therapy prior to consideration of a MUA. The claimant has not completed the recommended six weeks of physical therapy. MUA is not medically necessary at this point in time, based on the ODG requirements for this procedure. Therefore, after reviewing the medical records and documentation provided, the request for OP Repeat Left Knee Manipulation Under Anesthesia 27570 is denied.

Per ODG:

Manipulation under anesthesia (MUA)	Recommended as an option for treatment of arthrofibrosis (an inflammatory condition that causes decreased motion) and/or after total knee arthroplasty. MUA of the knee should be attempted only after a trial (six weeks or more) of conservative treatment (exercise, physical therapy and joint injections) have failed to restore range of motion and relieve pain, and a single treatment session would then be recommended, not serial treatment sessions of the same bone/joint subsequently over a period of time. Following total knee arthroplasty, some patients who fail to achieve >90 degrees of flexion in the early perioperative period, or after six weeks, may be considered candidates for manipulation of the knee under anesthesia. (Namba, 2007) (Magit, 2007) (Keating, 2007) (Pariente, 2006) (Esler, 1999) This study advocates that MUA should be used for stiff knee arthroplasties after failed physical therapy. (Mohammed, 2009) 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. (Ipach, 2011) 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. (Ipach2, 2011) Ruptured pseudoaneurysm should be included in the differential diagnosis whenever a patient presents with pain and swelling of the thigh after MUA. (Sambaziotis, 2011) 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. (Bawa, 2012) Knees that underwent MUA for combat-related arthrofibrosis demonstrated significant improvements in arc of motion at 2-year follow-up with fewer complications, compared to arthrolysis surgery. (Evans, 2013) This systemattic review concluded that MUA for a stiff primary TKA is an efficacious procedure to restore range of motion, with early gains in motion maintained long term. The risk of periprosthetic fracture was low, making MUA a safe option for improving knee range of motion. (Pivec, 2013) Orthopedic surgeons, not chiropractors, should perform this. See also the Low Back Chapter, where MUA is not recommended in the absence of vertebral fracture or dislocation.

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)**