Vanguard MedReview, Inc.

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August 16, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left Knee Arthroscopy with PCL release

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

☒ Overturned (Disagree)

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 female who was injured on xx/xx/xx when she was working. She was on the seventh rung of an A-frame ladder that fell to the left side.

03/13/2014: UR. **Rationale:** The claimant has been continued on Ultram, Motrin, and Elavil for ongoing chronic left knee and low back pain stemming from the original injury. The claimant has continued to be symptomatic despite tertiary levels of treatment to include a chronic pain management program. At this point in time, current evidence based guidelines would not recommend ongoing use of NSAIDs. The chronic use of prescription NSAIDs is not recommended by current evidence based guidelines as there is limited evidence regarding their efficacy as compared to standard over-the-counter medications for pain such as Tylenol. Per guidelines, NSAIDs can be considered for the treatment of acute musculoskeletal pain secondary to injury or flair ups of chronic pain. There is no indication that the use of NSAIDs in this case is for recent exacerbations of the claimant's known chronic pain. As such, the patient could reasonably be transitioned to an over-the-counter medication for pain, IN regards to Ultram and Elavil, current evidence based guidelines does recommend the use of anti-depressants in the treatment of chronic musculoskeletal pain as a stabilizing medication. Given the failure of all other treatment to date, this reviewer would recommend continuation of this medication, Ultram is considered an optional medication for musculoskeletal pain. In this case, it is remarkable that the claimant has been able to avoid heavy narcotics use despite chronic symptoms. At this point in time, this reviewer would recommend continuing this medication for pain control. It is unclear why the claimant is being referred back to a pain management office.

This claimant has already failed a tertiary level chronic pain management program. At this point, it is unclear what additional clinical treatment could be recommended for this claimant outside the continuation of medications as recommended above.

04/10/2014: Office Visit. **HPI:** The patient presents for follow-up complaining of pain of the low back, left thigh, left knee and left ankle as a result of work related injury on xx/xx/xx. She was taken by a co-worker to, where she underwent x-ray, was injected for pain, splinted, provided crutches, and released. She was then evaluated at, where she received therapy. MRI revealed left knee meniscus tear., the orthopedic surgeon, proved surgery on 3/29/12. She underwent a course of post-surgical physical therapy. She reports having limited relief from treatment that she has received to this point. She reported having ongoing pain of the left low back, left thigh, and left knee. She presented here for evaluation and continued management of her condition. Patient stated she was re-evaluated by on 5/24/12 and was prescribed Ultram. She expressed the desire for evaluation by an alternate orthopedic surgeon. She was examined and referred to orthopedic surgeon for second opinion. The additional therapy for the left knee was denied by the carrier. The appointment with was denied by the insurance carrier. The left knee MRI on 8/8/12 showed near complete disruption of the ACL, baker's cyst and chondromalacia. The lumbar MRI on 8/24/12 showed multiple disc protrusion. The EMG/NCV of LE on 9/19/12 showed possible mild left sural sensory neuropathy with mild reduction of latency observed. Patient doesn't want any LESI. She was re-evaluated by on 9/20/12 and he recommended steroid or viscosupplementation injection. She discontinued Flexeril because she did not like how it made her feel, she could not sleep, and she had headaches. She discontinued Ultram because it did not sufficiently manage her pain. She started the chronic pain management program. The carrier did not pay for Zoloft, and she continues to be depressed. She was evaluated by designated doctor on 1/8/13 and was found to be at MMI as of 6/28/12 and was given 1% IR. On 1/30/13 patient was crying and stated of loss of appetite and she felt sad. The patient stated Cymbalta makes her tongue feel numb and hives all over her body. Recommended patient to discontinue Cymbalta and was prescribed Elavil today. Patient completed 160 hrs of CPM and the additional sessions were denied by the carrier. She was re-evaluated by on 4/15/13. The compound cream was denied by the carrier based on peer review. She underwent left knee injection on 5/15/13. ON 6/27/13 recommended left knee surgery. The total knee arthroplasty was denied once by the carrier. She was re-evaluated by on 8/28/13 and he recommended putting off total knee replacement as long as possible. She wanted a second opinion regarding her ongoing left knee pain. The CCH decision: Claimant has not reached MMI and therefore no IR is assigned. The compensable injury of xx does extend to and include aggravation of the degenerative joint disease and chondromalacia of the left knee, and disc protrusions/herniation at T11-T12, T12-L1, L2-L3 and L4-L5. She was interested in proceeding with lumbar injection. She was evaluated by on 2/14/14 and he stated patient may benefit from knee replacement. She was evaluated by on 2/21/14 and he recommended LESI. She underwent LESI on 3/18/14. Patient states that the LEISI helped for couple of days. She reports of persistent back and left knee pain. She states she has difficulty getting in and out of the tub, going up and down the stairs due to left knee pain. She states of numbness of left thigh. Patient states Ultram 50mg is not helping with pain therefore increasing it to 100mg. **Objective Clinical Findings:** She ambulates with an antalgic gait. Examination of the lumbar spine reveals tenderness of lumbar paraspinals on the left side. Tenderness also noted of the left S1 joint upon palpation. Lumbar ROM are restricted with increase in pain. Kemps test is positive on the left straight leg raise test is positive on the left. There is diminished sensation over the L5 and S1 dermatomes on the left. Examination of the left thigh reveals tenderness over the quadriceps and hamstrings. Examination of the left knee reveals severe tenderness at medial and lateral aspect upon palpation. Left knee ROM are restricted with pain. Varus and valgus stresses are positive. McMurray's test is positive. There is weakness of left knee. **Plan:** Pending to start post-injection therapy for lumbar spine, pending post-injection follow-up with on 4/11/14, Refer for left knee MRI, Medication: Ultram 100mg one bid #60, Elavil 25mg one qhs #30, Motrin 600mg one bid #60, Work status: Temporarily disabled, Follow-up 4 weeks.

06/12/2014: Office Visit. **HPI:** Patient was re-evaluated by and he recommended lumbar discogram The lumbar discogram was denied by the carrier. She underwent EMG/NCV of LE, report not available. She states ongoing back pain. She states of numbness and pain referred to left leg. She states her left knee pain is getting worse. She states she has difficulty going up and down the stairs due to left knee pain. She states Nalfon is not helping with pain therefore switching to Vicodin. **Plan:** Pending follow-up with on 6/18/14, Medication Elavil 25mg one qhs #30 and Vicodin 5/325mg one bid #60 (Patient states Elavil helps with depression) Work Status: temporarily

disabled, follow up 4 weeks

07/02/2014: Office Visit. **HPI:** The patient is seen in for a follow up on her knee injury. Evidently, she got approved for further surgery for knee replacement on the left knee. **Plan:** I explained to her that we will have her evaluated by another doctor for the knee replacement since I do not perform that type of surgery.

07/25/2014: Orthopedic Consultation. **HPI:** Patient was referred to me and present s with severe left knee pain. She has popping and inability to bend her knee. She also complains of 5/10 low back pain with some numbness in her leg. **Physical Examination:** Her back has some tenderness with decrease ROM. Her left knee has extension of 2° of flexion contracture and 35° of flexion, which is limited by pain. Her knee was ligamentously stable to varus and valgus stress. She had medial and lateral joint line tenderness as well as patellar facet tenderness. Distally her motor strength and sensation were intact and the dorsalis pedis pulse was 2+. Capillary refill was less than two seconds. Review of Diagnostic Studies: X-rays of the left knee and lumbar spine were obtained today. The left knee has tricompartmental arthritis, worse in the medial compartment, but also rather severe I the patellofemoral joint. Lumbar x-rays reveal minimal age-related changes, but otherwise are unremarkable. **Impression:** 1. Osteoarthritis, left knee. 2. Lumbar protrusions. **Plan:** 1. had concern about the patient's diagnosis and its compensability. Apparently aggravation of arthritis is compensable. The patient was tolerating her level of arthritis without difficulty prior to her accident and it was only after that she became symptomatic. Since the total knee replacement is medically necessary to treat the aggravation to her arthritis and not the underlying arthritis, it would seem that the total knee replacement is medically necessary to treat the effects of the compensable injury. We are going to try and track down the copy of the patient's surgery approval, and then we will go ahead and schedule the patient's left total knee arthroplasty. 2. The patient's only other medical problem is hypertension. A simple letter form a primary care physician would be sufficient in helping her clear for surgery.

09/15/2014: Operative Report. **Postoperative Diagnosis:** Aggravation of arthritis, left knee. **Procedure:** Left total knee arthroplasty using ortho development balanced knee size 5 femur, size 4 tibia, size 32 patella with 7mm polyethylene insert.

10/08/2014: Orthopedic Report. **HPI:** Patient returns for follow-up after left knee total knee arthroplasty on September 15, 2014. She complains of 5/10 lumbar pain with numbness going to her left leg, to the 4th and 5th digits of her left foot. She is using CPM machine, but she has not been doing any supervised physical therapy. **Physical Examination:** On exam, the patient's left knee has minimal erythema around the incision, which is consistent with healing. There is no discharge or wound breakdown. There is some mild swelling in the area, but it is less than before. Her ROM went from 10° of flexion to 80° of flexion with an easy, fluid arc. The pain did not increase until she got the ends of her arc. **Impression:** 1. Status post left total knee arthroplasty. 2. Multiple disk protrusions. **Plan:** 1. With regard to the patient's left knee, the ease of which she has ROM and the lack of wound discharge or breakdown suggests the lack of infection. The Doppler ultrasound of the lower extremities was also negative for DVT. As a result, I would like this patient to start her postoperative PT as soon as possible. A prescription was given to for that. 2. I will see the patient back in 4 weeks. 3. With regard to her back and leg symptoms, the numbness in the 4th and 5th digits of her left foot is not easily described by her EMG findings, not is it explainable by her MRI images. I do not anticipate the need for lumbar surgery. However, if elects to send the patient for an epidural steroid injection, that may help control her pain.

01/12/2015: Operative Report. **Postoperative Diagnosis:** Stiffness, left knee **Procedure:** Aborted manipulation under anesthesia, left knee.

03/23/2015: Operative Report. **Postoperative Diagnosis:** Stiffness, left knee **Procedure:** Manipulation under anesthesia, left knee.

04/09/2015: Orthopedic Report. **HPI:** Patient complains of pain and stiffness in her left knee. She also has 5/10 low back pain. Since the patient's manipulation under anesthesia, she has not had any supervised physical therapy, however, it is my understanding that she is scheduled to start tomorrow. **Physical Examination:** On exam today the patient had a well-healed surgical incision anteriorly. ROM goes from 15° of flexion contracture to

approximately 90° of flexion. Her knee is ligamentously stable. She is able to bear weight but with some pain. Distally, she is neurologically intact. **Impression:** Status post left total knee arthroplasty with stiffness. **Plan:** 1. It appears that after the manipulation under anesthesia we were able to gain some additional flexion. However, the patient has a 15° flexion contracture which is interfering with walking. I recommended progressive static stretching splint, which was ordered for her left knee at this time. In addition, I think it is important that the patient participate in supervised physical therapy. So far it appears she has only had one course of physical therapy, and it seems that it started two months after her surgery. The importance of stretching was emphasized tot the patient. 2. She is no longer taking the Tylenol 3 but is taking Ultram. I believe that is a reasonable pain medication for her. I believe she should also be on a nonsteroidal anti-inflammatory if her other medical problems can tolerate it. 3. Follow-up in 4 weeks.

05/28/2015: Orthopedic Report. **HPI:** Patient returns for follow-up on her back and left knee injury. The patient underwent a total knee arthroplasty on September 15, 2014. Postoperatively, she had limitations in ROM and weakness. She has been participating in a postoperative physical therapy program, which has given her some improvement. She has been using her static stretching splint 3 times a day for approximately 30 minutes. She was advised to increase that time frame. She still complains of a popping, clicking sensation, and swelling in her knee. She does not use any orthopedic ambulatory devices. She has low back pain she rates 3/10. She complains of left lower extremity numbness, tingling, and weakness. **Physical Examination:** There is visible swelling of the left knee, mostly on the lateral aspect. Her extension has improved with approximately 5-10° of extension lag. Her flexion is approximately 90° with difficulty. Her knee is ligamentously stable. She is able to bear weight with some pain. She was intact distally. **Impression:** Status post left total knee arthroplasty with stiffness. **Plan:** She was advised to aggressively use her static knee brace and increase her activity. She was advised of various at home exercises and stretching to help with her ROM and strengthening. I want to give her a little more time to see if she can improve her ROM. We did discuss the option of a left knee arthroscopy with PCL release.

06/09/2015: UR. **Rationale for Denial:** This patient is xx years old and has advanced chondrosis of the left knee and then had a left total knee arthroplasty performed. She has a 30° flexion contracture. The proposed procedure is an arthroscopy with PCL release by. The patient has already had a manipulation under anesthesia which was not very helpful. The operative reports were forwarded but the specifics (PCL retraining or substituting) were not provided. This patient needs a _____ ____ total _____specialist evaluation before any further consideration for surgery is entertained.

06/29/2015: Letter of Medical Necessity. This is a letter of medical necessity for a left knee arthroscopy with lysis of adhesions on PCL release to improve postoperative range of motion. I am in receipt of a preauthorization denial dated June 9, 2015, in which the proposed procedure was denied. stated that he could not determine if the proposed procedure was medically necessary because he could not determine of the implanted total knee arthroplasty was either PCL retaining or substituting. Review of the x-rays show that he femoral component does not have a box and therefore is not PCL substituting. This is consistent with the fact that all uncomplicated primary total knee arthroplasties that I perform are performed with PCL retaining components. I hope this clarifies the matter.

06/30/2015: UR. The request for a left knee arthroscopy with a PCL release is non-certified. The documentation indicates the patient complaining of ongoing left knee pain despite a previous completion of conservative therapies and manipulation under anesthesia. The procedure involving a PCL repair continues to be under study as no high quality studies have been published in peer reviewed literature supporting the safety and efficacy of the proposed procedure. Without confirmatory evidence in place, it is unclear if the patient would fully benefit from the proposed procedure. Therefore, this request is not indicated as medically necessary. Reference: The ODG, Knee and Leg Chapter, online version: Posterior cruciate ligament (PCL) repair Under Study. Injuries of the posterior cruciate ligament (PCL) of the knee frequently occur in automobile accidents and sports injuries, although they are less frequent overall than injuries of the anterior cruciate ligament (ACL). Some patients show significant symptoms and subsequent articular deterioration, while others are essentially asymptomatic, maintaining habitual function. Management of PCL injuries remains controversial and prognosis can vary widely. Interventions extend from non-operative (conservative) procedures to reconstruction of the PCL, in the hope that

the surgical procedure may have a positive effect in the reduction/prevention of future osteoarthritic changes in the knee. No randomized or quasi-randomized controlled studies were identified. (Peccin-Cochrane, 2005)

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

The patient will benefit from a left knee arthroscopy with PCL release. The patient is currently dealing with limited knee motion, after a knee replacement performed on 9/15/2014, followed by a manipulation under anesthesia. The May 2015 office note indicates that the patient has a 5-10 degree extension lag and 90 degrees of flexion. The treating surgeon feels that her condition will improve with an arthroscopic PCL release. Arthroscopy with PCL release and lysis of adhesions is an accepted treatment for stiffness following knee replacement. The patient has a documented PCL retaining prosthesis. A simple arthroscopy to release the PCL and remove anterior scar tissue may be sufficient for this patient. This procedure may help avoid extensive open surgery to release the soft tissues and possibly revise the hardware. The requested surgery is approved.

REFERENCE

Bong MR, DiCeaser PE. Stiffness and Total Knee Arthroplasty. Journal American Academy Orthopaedic Surgeons, 2004; 12(3): 164-171

Per ODG:

Posterior cruciate ligament (PCL) repair	Under study. Injuries of the posterior cruciate ligament (PCL) of the knee frequently occur in automobile accidents and sports injuries, although they are less frequent overall than injuries of the anterior cruciate ligament (ACL). Some patients show significant symptoms and subsequent articular deterioration, while others are essentially asymptomatic, maintaining habitual function. Management of PCL injuries remains controversial and prognosis can vary widely. Interventions extend from non-operative (conservative) procedures to reconstruction of the PCL, in the hope that the surgical procedure may have a positive effect in the reduction/prevention of future osteoarthritic changes in the knee. No randomized or quasi-randomized controlled studies were identified. (Peccin-Cochrane, 2005)

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)**

Bong MR, DiCeaser PE. Stiffness and Total Knee Arthroplasty. Journal American Academy Orthopaedic Surgeons, 2004; 12(3): 164-171