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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XXXX knee XX with XX of XX

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

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☒ Partially Overturned	Agree in part/Disagree in part
☐ Upheld	Agree

CPT: XX Not medically necessary--XX of knee, surgical, with XX of XX
XX Is medically necessary--XX of XX joint under anestheisa

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX who was diagnosed with XXXX knee pain with XX, XXXX knee XX dislocation XX, XXXX ankle pain, and knee joint XX. XXXX and XXXX XX dislocated and XXXX had an XX pain. XXXX for the XXXX knee pain and XX. XXXX had significant functional limitations and XX pain within the XXXX knee, which was constant. XXXX was not able to get on the XX and also not able to perform XXXX duties as a XXXX. XXXX was unable to get into the XX. XXXX was unable to get on the XX. It was documented that XXXX prior range of motion was from XX degrees to XX degrees which was clearly appropriate documentation of significant functional limitations. XXXX had difficulty lifting XXXX and certainly XXXX and also difficulty bending over to XXXX. XXXX opined that XXXX had significant functional limitations and needed XX with XX of XX and XX under anesthesia. XXXX for physical therapy visit regarding XXXX knee pain. XXXX reported increased pain or discomfort in the XXXX knee. XXXX reported the knee XX when XXXX bent it or sat for too long. Some discomfort continued to be reported during XX-XX due to XX in the XXXX knee resulting in some discomfort along XX knee.

XXXX. XXXX reported that XXXX was doing well but continued to have XX XX pain in the knee. XXXX was walking with very XX gait and a XX XX motion. XXXX further commented that XXXX lacked significant motion of the knee and had continued to have significant pain. XXXX recommended XXXX knee XX with XX of XX and manipulation under anesthesia. An MRI of the XXXX knee dated XXXX revealed findings consistent with XX XX XX XX, with bone XX and mild XX of the XX XX XX and XX aspect of the XX. There was XX of the XX XX XX with XX at the XX insertion. There was grade XX XX XX, with no XX high grade XX XX or acute XX defects identified and moderate joint XX. XX of the XX root insertion XX XX with no evidence of meniscal tear and soft tissue XX were noted. Treatment to date consisted of medications (XXXX), physical therapy and ice application.

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

The ODG supports a manipulation under anesthesia for the treatment of XX when there has been a failure of XX weeks of conservative care including physical therapy, and/or XX/XX, and/or joint injection. Additional criteria include pain and functional limitations despite conservative care, limited range of motion included flexion less than 90° and/or extension loss greater than 10°, and an absence of contraindications. Additionally, there should be less than XX months from the time of injury. The documentation provided indicates that the injured worker has ongoing complaint of knee pain, significantly reduced range motion, and an XX gait after suffering an injury on XXXX. A physical examination on XXXX documented a persistent XX gait, decreased range of motion, pain, and range of motion of XX°. The injured worker has failed to improve with more than XX weeks of conservative care including physical therapy and XX-XX medications. Based on the documentation provided, the ODG would support the requested manipulation under anesthesia as there has been persistent decreased range of motion which contributes to pain and a persistent XX gait that has failed to improve with conservative care. Therefore, the requested manipulation under anesthesia is established as medically necessary. The ODG supports XX XX of XX when an injured worker meets criteria for manipulation under anesthesia, there has been more than XX months since the injury, there is a contraindication to manipulation under anesthesia, or a prior failed manipulation under anesthesia.

The documentation provided indicates that the injured worker meets criteria for manipulation under anesthesia, so the request is medically necessary and overturned; however, there has not been a prior XX manipulation under anesthesia or contraindication to a manipulation under anesthesia. Therefore, the requested XX XX of XX would not be medically necessary and is upheld.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

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