



Washington State Department of Labor & Industries

Public Comments and Draft Responses Knee Surgical Guideline April, 2016

Comment Source: name, date, route	Comment	L&I Draft Response	Change Made
Margaret Baker MD, 3/25/16, email	On page 4 of the guideline draft for MAT, under Imaging I would delete “posterolateral” radiographs and substitute “AP, notch and lateral weight-bearing radiographs”. Thanks for all the work everyone put in on the new Guidelines to date!	The 'posterolateral radiographs' was an error and it will be changed	Language changed to: Weight bearing AP and lateral; with or without notch view
Fred Huang MD, 3/29/16, email	<p>1. On page 2 in regards to 1st time patellar dislocations, there should be an option for surgical treatment IF there is a chondral or osteochondral loose body present on x-ray or MRI. There is debate about whether or not the surgery should be a loose body removal or fragment ORIF only, or if patellar re-alignment surgery should be done concomitantly, but at the least the surgeon should be allowed to intervene for the loose body without having to try PT or non-operative care first.</p> <p>2. On page 3, I would suggest changing the criteria for an acute meniscal tear to involve knees that are KL grade 0,1 OR 2 based on films rather than just 0 or 1. the other option would be to expand the subjective criteria for an acute meniscal tear in a "degenerative" knee to more than just locking (i.e. add swelling, painful catching, and stiffness to the subjective column for acute meniscal tear in a "degenerative" knee to cover KL grade 2 knees)</p> <p>3. On page 4 for meniscal allografts the x-ray section says "posterolateral radiographs" which doesn't really make sense. Maybe they meant standing AP and lateral radiographs? Also in the same section it talks about Outerbridge scoring but they don't mention MRI as a requisite test and in general radiologists don't always specify what the Outerbridge score is in their knee MRI reports. May be better to change their Outerbridge score to KL instead for that section?</p>	<p>1. Agree that osteochondral injuries are common with first-time patellar dislocation and surgical treatment may be needed.</p> <p>2. There is insufficient evidence in the medical literature to support this.</p> <p>3. Agree that adding KL score language will add clarity.</p>	<p>1. Changed non-operative care section to: 6 weeks of physical therapy is <u>required</u> for first time dislocation; physical therapy is not required for recurrent dislocations or if loose osteochondral body is confirmed by MRI or x-ray and needs to be surgically addressed.</p> <p>2. No action or change</p> <p>3. Language added: radiographs show: KL score < 2</p>



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<p>Physical Therapy Association of Washington (PTWA) Erik Moen, PT, DPT, President 4/11/16 email</p>	<p>PTWA supports recommendation of physical therapist interventions for the following:</p> <ul style="list-style-type: none"> • <i>Patellar tendon realignment procedure with or without lateral retinacular release</i> • <i>Repeat arthroscopic meniscectomy in the absence of new injury (in a non-degenerative knee)</i> • <i>Anterior cruciate ligament (ACL) reconstruction</i> 	<p>Comment supports guideline</p>	<p>No action or change</p>
	<p>PTWA recommends <u>requiring</u> at least 6 weeks of physical therapist interventions before surgery and not be listed as an option for the following:</p> <ul style="list-style-type: none"> • <i>Meniscectomy, full or partial (in a non-degenerative knee)</i> • <i>Meniscal allograft transplantation</i> • <i>Marrow stimulating techniques: microfracture or subchondral drilling or abrasion arthroplasty</i> • <i>Osteochondral autograft/allograft transplantation (mosaicplasty or OAT procedure for the knee)</i> 	<p>Physical therapy needs can vary with each patient and the benefits are not consistent or conclusive. We prefer to leave it to the physician's discretion to order physical therapy on a case by case basis.</p>	<p>No action or change</p>
	<p>PTWA recommends <u>requiring</u> at least 6 weeks of physical therapist interventions before surgery for the following:</p> <ul style="list-style-type: none"> • <i>Uni-compartment knee arthroplasty (UKA-partial knee replacement)</i> • <i>Total Knee Arthroplasty (TKA)</i> 	<p>Physical therapy needs can vary with each patient and the benefits are not consistent or conclusive. We prefer to leave it to the physician's discretion to order physical therapy on a case by case basis.</p>	<p>No action or change</p>
	<p>PTWA supports including and defining “clinically meaningful improvement in function” measures as a way to identify conservative therapy outcomes. Often the baseline measures are reported without follow-up, so no assessment can be made regarding improvement or lack of improvement. Requiring documentation of a 30% improvement over baseline can help reduce costs by denying authorization and payment for continued conservative intervention for lack of progress or by reducing the number surgical interventions.</p>	<p>Comment supports guideline</p>	<p>No action or change</p>



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	<p>P. 12 C. <i>Non-operative care</i>. PTWA recommends <u>requiring</u> a trial of physical therapist interventions as a prerequisite to surgical care for the knee. In addition, PTWA recommends <u>requiring</u> that exercise, strength training, activity modification and a prescribed home exercise program be provided by a physical therapist.</p>	<p>Physical therapy needs can vary with each patient and the benefits are not consistent or conclusive. We prefer to leave it to the physician's discretion to order physical therapy on a case by case basis.</p>	<p>No action or change</p>
	<p>P. 15 D. <i>Meniscal disorders. Repeat Meniscectomy</i>. PTWA supports requiring physical therapist intervention for a minimum of 12 weeks post-initial surgery before a repeat surgery.</p>	<p>Comment supports guideline</p>	<p>No action or change</p>
	<p>P. 15-16 D. <i>Meniscal disorders. Meniscal allograft transplantation</i>. PTWA recommends <u>requiring</u> physical therapist intervention for the extensive rehabilitation period.</p>	<p>Physical therapy needs can vary with each patient and the benefits are not consistent or conclusive. We prefer to leave it to the physician's discretion to order physical therapy on a case by case basis.</p>	<p>No action or change</p>
	<p>P. 19. G. <i>Arthroplasty. Uni-compartment arthroplasty and total arthroplasty</i>. PTWA recommends <u>requiring</u> physical therapist intervention pre-operatively based on the Bree document for total knee and total hip replacement surgery (Bundle) recommendations: 1. Conservative therapy for at least 3 months and 2. Fitness for surgery: obtain relevant consultations; consult physical therapy.</p>	<p>L&I strongly endorses the Bree Collaborative recommendations included in the Total Knee and Hip Replacement Bundle. The Bree Collaborative recommends conservative care and relevant consultations to provide customized patient care, which can only be achieved by the physician's discretion.</p>	<p>No action or change</p>



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	<p>PTWA recommends <u>requiring</u> physical therapist intervention after all knee surgeries. The Bree document for total knee and total hip replacement surgery (Bundle) recommends physical therapist intervention starting on the day of surgery. LNI Guidelines should be consistent with the Bree Collaborative guidelines to ensure that state health care policies are consistent and do not conflict</p>	<p>L&I strongly endorses the Bree Collaborative recommendations included in the Total Knee and Hip Replacement Bundle. The Bree Collaborative recommends conservative care and relevant consultations to provide customized patient care, which can only be achieved by the physician's discretion.</p>	<p>No action or change</p>
	<p>Finally, to be clear the term "physical therapy" is not generic. By law, "physical therapy" means the care and services provided by or under the direction and supervision of a physical therapist (RCW 18.74.010(9)). Hence, our PTWA recommendation is to change the language in the draft from "physical therapy" or "PT" to physical therapist intervention.</p>	<p>The current guideline language does not conflict with state law. By using term "Physical Therapy," the option to use physical therapy assistants and aids is preserved.</p>	<p>No action or change</p>
<p>Jonah Hulst, MD on behalf of Proliance Orthopaedics & Sports Medicine Partners, 4/11/16, email</p>	<p>With regard to Section G: Arthroplasty, specifically Uni-compartmental Knee Arthroplasty (UKA), this document suggests a relative contraindication in patients that are younger than 60 years of age.</p> <p>Two papers are referenced with this guideline. The first, 68, <i>Unicompartmental knee arthroplasty, a 4.5-6 year follow-up study with a metal-backed tibial component</i>. This study was published in 1989, does not represent current practice and references an outdated implant. The second, 62, <i>Unicompartmental Knee Arthroplasty: Past, Present, and Future</i> is from 2012, and when reviewed closely, suggests an expanded indication for UKA to patients older than 40 years of age.</p>	<p>The age is listed in the narrative section as a relative contraindication; we decided not to list it as a criterion for approving surgery.</p>	<p>No action or change</p>



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	<p>Additionally, isolated medial compartment arthrosis can be common after meniscal injury. Patients between 40 and 60 years of age are often excellent candidates for this procedure for the very reasons outlined by Labor & Industries: better kinematics, less invasive, and the like.</p> <p>Proliance Orthopaedics & Sports Medicine supports an expanded age range for UKA. We strongly encourage Washington State Department of Labor and Industries to consider allowing UKA to patients older than 40 years of age.</p>		
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