

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 7, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical bills for work hardening from May 8, 2007, through June 15, 2007

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

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation does not support the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Texas Department of Insurance:

- Medical bills, WHP (05/08/07 – 06/15/07)
- Billing retrospective reviews (07/13/07 – 09/30/07)

Managed Care, Inc.:

- Office notes (04/19/06 – 06/19/07)
- Chiropractic therapy notes (01/06/06 – 03/30/07)
- Physical performance evaluations (05/04/06 – 06/19/07)
- Radiodiagnostic studies (10/18/06 – 05/03/07)
- Procedures (12/05/06, 02/20/06)
- Reviews (08/14/06 – 05/03/07)

Pain and Wellness:

- Office notes (12/05/05 – 06/28/07)
- Chiropractic therapy notes (01/06/06 – 09/26/07)

- Physical performance evaluations (04/27/06 – 06/19/07)
- Radiodiagnostic studies (10/18/06)
- Procedure notes (12/05/06 and 07/17/07)

M.D.:

- Designated doctor evaluation (05/03/07)
- Radiodiagnostics (05/03/07)

Rehabilitation Center:

- Office notes (05/01/06)
- Physical performance evaluations (04/26/07 – 06/19/07)
- Work hardening program notes (04/30/07 – 06/15/07)
- Radiodiagnostic studies (05/03/07)
- Designated doctor evaluation (05/03/07)
- Billing retrospective review (07/13/07)

Guidelines utilized in denials: Official Disability Guidelines and American Physical Therapy Association Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old patient who was injured on xx/xx/xx. He was moving down some steps when his left knee popped and buckled. He fell forward and landed on his left knee. He had immediate swelling and was unable to bear weight fully afterwards.

On xx/xx/xx, D.O., evaluated the patient for left knee pain and swelling; diagnosed left knee sprain/strain and secondary osteoarthritis of the lower leg; and prescribed Naprosyn and Vicodin. M.D., noted a history of left thigh surgery at age of 15 and left knee surgery at age 21. Magnetic resonance imaging (MRI) of the left knee demonstrated chondromalacia patella, irregularity of the posterior horn of the lateral meniscus suggestive of chronic meniscal pathology, a small parameniscal cyst posterior to the medial meniscus suggesting a tear, tricompartmental degenerative changes, and a Barker's cyst.

From January through February 2006, the patient attended 15 sessions of chiropractic therapy.

On February 20, 2006, M.D., performed left knee arthroscopic abrasion arthroplasty and debridement of the trochlea and patella, arthroscopic lateral release, debridement, and microfracture technique on the medial and lateral femoral condyle and a partial lateral meniscectomy. Following this, the patient attended 26 sessions of chiropractic therapy.

Serial functional capacity evaluation (FCE)/physical performance evaluations (PPE) performed from April through June indicated that his lifting capacity was progressing from the light-to-medium category to the medium category against his job requirement of a medium to heavy category. The patient was felt to be at

a very high risk of re-injury. Work hardening program (WHP) was recommended. In May, a psychological evaluation assessed adjustment disorder with mixed anxiety and depressed mood. In July, Dr. injected the left knee with a steroid preparation and noted excellent short-term improvement. But due to the presence of a large effusion and pain, Dr. believed there was some definite intraarticular pathology and the patient would not improve further without surgical intervention.

M.D., a designated doctor, recommended continuing a quadriceps strengthening program with a short arc quadriceps program, utilizing oral anti-inflammatory drugs and steroid medications on a judicious basis, failing which repeat surgery might be indicated in the future. A PPE in September indicated the patient to be lifting in the medium category. A psychological evaluation offered no barriers to WHP.

In October 2006, magnetic resonance imaging (MRI) of the left knee demonstrated: (a) changes in the posterior horn and posterior body of the lateral meniscus possibly reflecting tear or prior meniscectomy; (b) advanced osteoarthritic changes in the anterior compartment with moderate-to-severe articular cartilage loss, prominent osteophytes, and severe joint space narrowing; (c) moderate osteoarthritic changes in the medial and lateral compartments evidenced by osteophyte formation and some chondromalacia; (d) moderate-sized joint effusion; and (e) markedly diminutive iliotibial band with atrophy of the vastus lateralis muscle. MRI of the right knee demonstrated insertional quadriceps tendinopathy; moderate chondromalacia of the lateral patellar facet near the apex; a small joint effusion; and a small Baker's cyst.

On December 5, 2006, Dr. performed a left knee arthroscopy with abrasion arthroplasty/microfracture technique of the medial femoral condyle and trochlea, and debridement of the left knee.

From January through April 2007, the patient underwent chiropractic therapy in the form of neuromuscular re-education, manual therapy, therapeutic exercises, and kinetic activities. In February, Dr. noted that the left knee was significantly better with only some mild effusion, but the right knee had worsened. The right knee was injected with a steroid preparation. In March, Dr. injected the right knee on two occasions.

A repeat PPE in April demonstrated the patient to lift in the medium-to-heavy category. M.D., a designated doctor, assessed clinical maximum medical improvement (MMI) as of May 3, 2007, and assigned 6% whole person impairment (WPI) rating.

From April 30, 2007, through June 15, 2007, the patient attended WHP. A PPE performed in June demonstrated the patient's lifting capacity in the light-to-medium category. A psychological evaluation diagnosed pain disorder with depression; noted minimal progress with WHP; and recommend a chronic pain management program (CPMP).

On July 13, 2007, a retrospective billing review was performed, which determined that the WHP was not appropriate. Rationale: *Review of recent multiple PPEs indicated that the patient did not have generalized deconditioning nor evidence of any systemic neuromusculoskeletal deficits. It appeared that the knee pain was inhibiting the patient's return to work, and as such, WHP would not be indicated.*

On July 17, 2007, Dr. performed arthroscopy of the right knee with abrasion arthroplasty of the patella, arthroscopic lateral release, lateral retinacular release, debridement of medial femoral condyle, and injection of the right knee and insertion of a non-biodegradable drug delivery device/pain pump catheter. From July through September, the patient underwent chiropractic therapy.

On September 30, 2007, another retrospective billing review was performed, which did not recommend the WHP performed. Explanation: *Tests performed in April 2007 found that the patient at a severe pain level and at a very high risk of re-injury and this did not appear to support that the patient was a good candidate for WHP. There was a question of whether the patient could achieve or not achieve goals. Further information was necessary to support the program, and attempt was made at obtaining information, but was unsuccessful.*

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

Based on the records reviewed, the claimant was reported to be in the medium to heavy physical demand level with the physical performance evaluations obtained on 03/14/07 and 04/04/07. This matches his pre-injury work required physical demand level and would preclude the reasonable requirement for the intensive multidisciplinary program. Official Disability Guidelines criteria require that a defined return to work goal agreed to by the employer and employee be documented prior to beginning a work hardening program. This was not documented in the records. In addition, the claimant was certified at maximum medical improvement by the designated doctor who specifically stated that further treatment was not required. Therefore, based on the records provided and following appropriate guideline parameters, the medical necessity of the work hardening program was not established.

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**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**