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Notice of Independent Review Decision

DATE OF REVIEW: November 19, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional work hardening 5 x week x 2 weeks, left elbow, 97545 & 97546

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

Fellow American Academy of Physical Medicine and Rehabilitation
Member of PASSOR

REVIEW OUTCOME

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

X 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

- Utilization Reviews (10/06/09 – 10/15/09)
- Office Visits (05/26/09 - 10/19/09)
- Diagnostics (05/21/09 – 07/28/09)
- Therapy Notes (06/04/09 – 10/08/09)
- Operative Notes (05/29/09)

- Utilization Reviews (10/06/09 – 10/15/09)
- Office Notes (10/19/09)
- Therapy Notes (09/30/09 – 10/08/09)

ODG Criteria has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his left elbow on xx/xx/xx, when he fell down about eight feet from a platform at work.

On May 11, 2009, M.D., evaluated the patient for generalized pain in the left arm, more in the elbow area. X-rays revealed displaced fracture at the left elbow. Dr.

placed the patient in a sugar tong splint and referred him for an orthopedic evaluation.

Computerized tomography (CT) of the left upper extremity revealed a comminuted radial head fracture with possible small fracture of the coronoid process of the ulna and possible small avulsion fracture of the olecranon process; few comminuted fracture fragments within the elbow joint with mild-to-moderate amount of joint effusion; and posterior elbow edema with thickening of the olecranon bursa, most likely due to posttraumatic bursitis.

M.D., an orthopedic surgeon, noted swelling and tenderness of the hand, ecchymosis in the forearm, and tenderness at the elbow with markedly decreased range of motion (ROM) secondary to pain. X-rays revealed dislocated radial head laterally with fracture of the neck of the radius with lot of comminution.

On May 29, 2009, Dr. performed implant arthroplasty of the radial head on the left and debridement of the joint.

From June 10, 2009, through August 7, 2009, the patient attended 24 sessions of physical therapy (PT) consisting of manual therapy, therapeutic exercises, neuromuscular re-education, and electrical stimulation.

In June, Dr. noted complaints of pain in the left wrist and left shoulder. X-rays of the left shoulder and wrist were obtained. X-rays of the wrist showed a separation between the scaphoid and the lunate, but no instability.

On July 28, 2009, magnetic resonance imaging (MRI) of the left wrist revealed carpal joint effusion and physiologic communication with the pisotriquetral joint as well as small distal ulnar joint effusion, surrounding soft tissue edema; punctate foci of increased marrow signal throughout the carpus, non-specific finding occasionally noted with reflex sympathetic dystrophy (RSD); negative ulnar variant with degeneration of distal radioulnar joint; mild tenosynovitis affecting the contents of the first and second extensor tendon compartments proximally as well as the extensor digitorum tendon distally. Dr. prescribed Celebrex and Lyrica and recommended conservative treatment for the wrist.

On September 10, 2009, in a functional capacity evaluation (FCE) the patient qualified for a light-medium physical demand level (PDL) versus medium PDL required for his job. Physical/occupational therapy (PT/OT) and work hardening program (WHP) was recommended.

Through September 30, 2009, the patient attended 10 sessions of a work conditioning program (WCP). It was noted the patient had progressed well with tolerance to work conditioning exercise in the first week of two hours. The patient tolerated work simulation activities well; however, with increase in time the patient had increased pain after four hours especially in his left wrist. He continued to have significant limitation with his physical lifting demands. In an FCE, the patient qualified for safe recommended PDC of light medium category. It was felt that he would benefit from continued WHP/WCP or PT program.

On October 6, 2009, M.D., denied the request for WHP 5x a week x2 weeks with the following rationale: *“The patient sustained an injury on xx/xx/xx. The records submitted for review do not contain clinical information from the provider or the treating physician regarding a recent clinical assessment of the patient. As per FCE conducted on September 30, 2009, the patient is currently complaining of wrist pain and elbow pain with supination or weight bearing and overhead shoulder activities. This request is for ten additional work hardening sessions. However, progress notes from the previous work hardening visits to document functional progress were not provided for review. In addition, there was no clinical documentation of the patient in plateau from improvement from previous adequate trial of physical or occupational therapy prior to the proposed service. Hence, the necessity of this request at this juncture has not been established.”*

On October 15, 2009, M.D., denied the appeal for work hardening program 5x a week x2 weeks for the left elbow with the following rationale: *“The patient is status post ORIF left elbow and has completed 10 sessions of work conditioning to date. The current request is for work hardening; however, the patient has been participating in work conditioning. ODG recommends a WHP should be completed in four weeks consecutively or less and treatment is not supported for longer than one to two weeks without evidence of patient compliance and demonstrated significant gains as documented by objective gains and measurable improvement. ODG recommends a maximum of 12 visits for work conditioning. The patient has completed 10 sessions to date. There is no physical exam submitted from the treating physician documenting reasons for excessive work conditioning. Additionally, as the question is submitted for additional work hardening, medical necessity is not established since the patient has not been participating in a WHP thus far. Therefore, the requested additional work hardening 5 x a week x 2 weeks for the left elbow 97545, 97546 is not medically necessary.”*

On October 19, 2009, Dr. noted the patient had remarkable improvement following two weeks of WCP. His left elbow ROM was 5 to 110 degrees of flexion, 80 degrees pronation, 15 to 20 degrees supination with pain at the extreme of supination. The elbow was stable to varus and valgus stress although he complained of some pain with extension, wrist dorsiflexion 60 degrees, tenderness in the first dorsal compartment and ulnar aspect of the wrist. Dr. diagnosed tenosynovitis of the first dorsal compartment or tendinitis or capsulitis of the ulnar aspect of the wrist. He recommended steroid injection to the first dorsal compartment and the ulnar aspect of the triangular fibrocartilage as well as two weeks of therapy with the consideration of releasing the patient to duty after the rehabilitation/WCP was over.

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

Injured worker has undergone 10 sessions of a work conditioning program and has recently been receiving conservative care for his left wrist injury consisting of planned corticosteroid injection and formalized PT. There is no report regarding completion of this treatment, nor the outcome from this treatment. Ongoing use of a WCP/WHP while the injured worker is continuing in lower level formalized PT/HEP in conjunction with intra-articular corticosteroid injections is not

reasonable or medically necessary. There is no supporting documentation regarding significant measured functional gains from the initial 10 sessions of WCP to support additional sessions as well: PT note on September 30, 2009, reported minimal improvement in ROM testing. There is no report of significant measured functional gains from the WCP compared to the initial functional PDL before starting the WCP.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**