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Notice of Independent Review Decision

DATE OF REVIEW: November 2, 2009

Amended: November 4, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Laser both eyes – 67145 Prophylaxis of retinal detachment (eg. Retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)

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

Fellow American Academy of Ophthalmology
Certified by the American Osteopathic Board of Ophthalmology
American Society of Cataract and Refractive Surgery
Member American College of Eye Surgeons – Houston Ophthalmological Society

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

Back Institute

Office visits (03/11/96 – 03/12/09)

- Review (06/26/95)
- Diagnostics (12/07/95 – 02/28/96)

TDI

- Office visits (08/23/95 – 08/31/09)
- Diagnostic (02/27/96)
- Utilization reviews (08/20/09 – 08/27/09)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who slipped on a wet floor while carrying a five gallon bucket and hit his head, back, neck, and eye on the left side on xx/xx/xx. There was loss of consciousness (LOC) for a few seconds.

1995: On June 26, 1995, D.C., performed a designated doctor evaluation (DDE) and diagnosed cervical, thoracic, and lumbar strain. He noted magnetic resonance imaging (MRI) of the lumbar spine had shown a transitional vertebra at the lumbosacral junction and a mild loss of bright signal in the two lower lumbar intervertebral discs. MRI of the cervical spine had shown a mild loss of bright signal in the intervertebral discs. Dr. assessed clinical maximum medical improvement (MMI) as of June 26, 1995, and assigned 3% whole person impairment (WPI) rating. He recommended returning to the primary health care physician for supportive care on an as needed basis and also to undergo psychological counseling to help him deal with his chronic pain.

Next day, the patient was seen at Medical Center emergency room (ER) for seizures and was discharged on Dilantin.

M.D., noted that the patient had undergone computerized tomography (CT) of the brain and electroencephalogram (EEG) at the hospital. He complained of pain and numbness around his ears and pain while moving his jaw. Dr recommended evaluation by the oral surgeon for temporomandibular joint (TMJ) pain.

MRI of the head with contrast revealed deep right sylvian fissure MCA distribution arteriovenous malformation with evidence of superficial drainage. Relative contributions of hemosiderin and flow was difficult to ascertain.

1996: M.D., performed threshold test. Cerebral arteriogram revealed right sylvian arteriovenous malformation and aneurysm of the anterior communicating artery.

On March 11, 1996, M.D., performed left frontal temporal craniotomy and clipping of anterior communicating artery aneurysm. The patient was discharged with Dilantin and Darvocet-N.

Ph.D., M.D., performed a neurological evaluation. He reported the following: Traumatic brain injury with LOC in all medial probability resulted in his having six or seven seizures subsequent to xx/xxxx injury. CT head in June 1995, at the time of the first seizure, was normal. He subsequently went on to have more seizures, more work-up and a subsequent aneurysm was discovered that was of no consequence in terms of the original work-related injury. The original work-related brain trauma was the direct cause of his seizure disorder, and the patient was not diagnosed properly nor was properly treated by the first physician who saw him. He was treated by chiropractors and orthopedic surgeons, who did not pay attention to the traumatic brain injury history, nor did they work it up properly.

1997: In May, M.D., noted initially, the patient had difficulty hearing, problems with vertigo, taste and smell, bruising about the eyes, and difficulty opening his jaw. He complained of forgetfulness, sleep disturbance, difficulty with relationships and increased irritability and depression. Examination revealed

diffuse tenderness and limited opening of his mouth to 2.2 centimeters with mild crepitus. He assessed seizure disorder. The report is incomplete.

In December, Dr. evaluated the patient for complaints of left eye pain, prescribed Tobradex eye drops, and recommended ophthalmic glasses.

1998: In March, a request for nasal septal reconstruction was made .

D.D.S., reported in August 1992, the patient had come to the clinic with multiple missing teeth, heavy calculus and compromised oral hygiene. In January 1996, he had come with pain in TMJ and was referred to Dr. for TMJ dysfunction. Current examination revealed caries, class II mobility of the teeth number 23-26, heavy supra and subgingival calculus, and mild trismus. Dr. diagnosed generalized moderate adult periodontitis and stated no further recommendations would be made until further resolution and treatment of TMJ pain.

2005 - 2006: The patient was seen by an unknown physician for eye pain; however, the reports are illegible. The patient was a known case of diabetes mellitus and hypertension.

2007: The patient was referred for evaluation of TMJ pain.

2008: In March, the patient was seen by M.D., for complaints of right eye. The patient stated the right eye had been jumpy since being started on Tegretol. Diabetic teleretinal imaging of eyes was normal and did not show diabetic retinopathy.

In June, M.D., saw the patient in neurology clinic after an episode of epilepsy and diagnosed intractable complex partial epilepsy. He reduced the dose of Tegretol, discontinued gabapentin, and prescribed VPA ER 500 mg.

2009: In February, O.D., prescribed new glasses for both eyes and referred the patient to M.D., for ocular hypertension in right eye and pigmented area in the left eye. Dr. noted lattice degeneration and atypical floaters on right eye. He diagnosed diabetes mellitus, ocular hypertension by history, and lattice degeneration in both the eyes. He recommended retina evaluation for lattice degeneration and retinal holes.

On March 12, 2009, M.D., saw the patient for a retinal evaluation. Examination revealed visual acuity with correction was 20/25 on the right and 20/20 on the left. Intraocular pressure was 19 in each eye. Anterior segment examination of both eyes demonstrated early nuclear sclerosis of both natural lenses. Peripheral examination on thermoscopy revealed a couple of areas of hyperpigmented lattice degeneration inferiorly with vitreous opacity inferonasally overlying the retina. Dr. assessed lattice degeneration of the left eye and recommended maintaining good glycemic and hypertensive control.

On August 17, 2009, M.D., evaluated the patient for pain in left eye after exposure to strong light and floaters in both the eyes. He assessed lattice degeneration and floaters and recommended laser of both the eyes.

Per utilization review dated August 20, 2009, a request for laser of both eyes was denied with the following rationale: *“Laser treatment for lattice degeneration may be indicated in the presence of atrophic retinal holes associated with subretinal fluid or a new tractional retinal tear associated with a posterior retinal detachment. In this case, neither an atrophic hole with subretinal fluid nor a tractional retinal detachment has been documented. Therefore, the medical necessity of the proposed laser treatment cannot be confirmed.”*

In a letter of appeal, Dr. opined that the patient had vitreous traction surrounding the lattice and symptoms of flashes and floaters in both the eyes. Dr. stated photocoagulation laser was appropriate and medically necessary therapy to treat the vitreous traction and lattice degeneration.

Per utilization review dated August 27, 2009, an appeal for laser on both eyes was denied with the following rationale: *“There was no evidence that prophylactic laser treatment of lattice degeneration, even with a history of vitreous traction, is beneficial. Without holes or tears, the literature says there is no real benefit in prophylactic laser. The request is not supported by the above mentioned reference. The previous adverse determination is upheld.”*

On August 31, 2009, Dr. noted lattice OD stable and RPE pigment OS.

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

The lattice degeneration described per records reviewed do not indicate atrophic retinal holes or tractional tear, also, no subretinal fluid is documented. Without documentation of retinal holes or tears, no benefit of prophylactic laser would be achieved.

This determination is based on source criteria: (1) Preferred Practice Pattern (Retinal Diseases – AAO 9/2208) and Clinical Experience.

There are no ODG guidelines that apply to laser treatment of lattice degeneration.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

AMERICAN ACADEMY OF OPHTHALMOLOGY

- 1) PREFERRED PRACTICE PATTERN: “RETINAL DISEASE AND VITREOUS DETACHMENT, SEPT, 2008**
- 2) FOCAL POINTS MAY, 1989: LATTICE DEGENERATION – NORMAN BYER, M.D.**