

MATUTECH, INC.

PO BOX 310069
NEW BRAUNFELS, TX 78131
PHONE: 800-929-9078
FAX: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: August 23, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cataract removal with lens implant of the right eye

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

Law Office

- Office visits (12/02/94 – 07/06/10)
- Diagnostics (03/13/95 - 01/05/10)
- Reviews (06/10/96 – 12/31/09)
- Utilization reviews (06/03/10 – 06/22/10)

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- Office visits (03/30/10)

TDI

- Utilization reviews (06/03/10 – 06/22/10)

Criteria used in analysis

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who had been working with xxxx since xxxx in xxxx department, On he developed various medical problems including pain to multiple body parts, cutaneous scleroderma with features of CREST syndrome, Raynaud's phenomenon and Sjögren's syndrome.

1994 – 1997: Before the incident was reported, the patient was treated by M.D., with medications for hypertension, thyroid, and pain conditions. He was also being seen by various other specialists for his primary health. After the continuous exposure to the chemicals in xxxx, Dr. believed the patient had developed a nonspecific autoimmune condition secondary to chemical exposure. He diagnosed connective tissue disorder classified as probable scleroderma, peripheral neuropathy and shortness of breath, anxiety and depression and chronic backache and stiffness of hands. He expected worsening of Raynaud's phenomenon. A toxicologist suggested further follow-up with endocrinologist and observation. A skin biopsy was consistent with actinic/solar keratosis in the right arm and scleroderma. Dr. stated the patient was totally and permanently disabled. In 1996, the patient was admitted with a longstanding history of hypertension and COPD. He was treated and discharged with the diagnosis of unstable angina, CAD, and history of nicotine dependence. In 1997, Dr. stated the carpal tunnel syndrome (CTS) was a part of connective tissue disorder caused from chemical exposure.

1998 – 2007: The patient was diagnosed with Sjögren's disease and treated with lubricating eye ointments and drops. Dr. treated him for scleroderma, chronic pain, peripheral neuropathy, CREST syndrome and Raynaud's phenomenon. There was no improvement noted and the patient was maintained on medications for these problems. In 2004, the patient underwent ablation of the lower puncta of bilateral eyes. He was treated with Nasacort AQ two sprays in each nostrils, Restasis two drops b.i.d. in each eye, Maxair auto inhaler, Phenergan, Zanaflex and hydrocodone. The patient's other problems included osteoarthritis, sacroiliac (SI) joint pain and trochanteric bursitis and was treated with injections, therapy and Jobst stockings. In 2007, he complained of "shattered glass" vision in the left eye and was referred to an ophthalmologist.

2008 – 2009: Dr. saw him for chronic pain syndrome with intractable problems, but stable on medications. On September 11, 2008, M.D., a pulmonologist, obtained chest x-rays and noted mild interstitial fibrosis. PFT showed severe airflow obstruction with reversibility. He gave trials of Spiriva and Symbicort. His medications included Chantix for smoking cessation, Ultram, terazosin, Phenergan, Nasacort nasal spray, Skelaxin, Maxair Autohaler, Lasix, Genoptic, Norco, Lyrica, hydrochlorothiazide, Nexium, Synthroid, Cymbalta, Enalapril and Kadian. ANA and rheumatoid factor were unremarkable. He received medication refills through November for respiratory complaints.

On April 21 2009, M.D., performed cataract extraction with posterior chamber implant of left eye. In June and July, Dr. administered Avastin injection to the left eye.

MEDICAL REVIEWS/DD/RMES:

06/10/96, D.O.: MMI date 03/15/95.

04/23/98, M.D.: 56% WPI rating.

02/18/02, M.D.: Diagnosis was cutaneous scleroderma with features of Crest syndrome. Arterial hypertension and peripheral neuropathy were not causally related to scleroderma.

06/03/03, M.D.: No clear-cut picture of both systemic sclerosis or Crest syndrome and the assumption that it was all due to occupational hazard was not based on substantial clinical data. Back pain, hypertension, edema were not related to work injury. The patient could probably work in sedentary capacity.

03/09/05, M.D.: Symptoms of dry eyes and dry mouth were probably due to Sjögren's syndrome, but the diagnostic criteria had not been fulfilled and the diagnosis cannot be made definitively. If scleredema was not compensable, then neither would the Sjögren's syndrome be.

02/21/06, Dr.: Appeal court had decided pulmonary aspects and dry eye syndrome or Sjögren's syndrome were compensable. Scleredema was previously acknowledged compensable. Vascular or neuropathic changes in the lower extremities were argued and later accepted as compensable. Hypertension, diabetes, and hyperlipidemia were not compensable. Pulmonary fibrosis did not appear to be classical of scleroderma nor did the lung damage was entirely due to tobacco. His treatment should include palliative treatment for musculoskeletal and arthritic processes, esophageal dysfunction problems with reflux esophagitis and nausea, treatment of discomfort or pain in the nervous system due to Raynaud's syndrome or its variant or neuropathy. DD had awarded a percentage for his autoimmune disease of thyroid gland. This was not challenged and the award thus made thyroid compensable.

03/08/08, Dr.: His treatment should be supervised by an ophthalmologist and board-certified rheumatologist from compensable point of view. The patient might require once a month visit with each of the two doctors, ophthalmologist and rheumatologist. Additional visits might be required for non-compensable problems such as lymphedema, various musculoskeletal pains, degenerative arthritis, and pathology within knee, hypertension, diabetes, and visual changes in the left eye.

05/07/08, Dr.: Sacroiliitis, lumbar pain, hip pain, or any acute left eye injuries were not related to the injury. Chronic generalized pain syndrome and fibromyalgia that the patient had developed could not be linked to chemical exposure or silica. Degenerative arthritis was not work related. However, with court decisions following ICD codes for the injury would include: circumscribed scleroderma (701.0), chronic pain syndrome (338.4), Sjögren's syndrome (710.2), and chronic lymphocytic thyroiditis also known as Hashimoto's disease (245.2).

11/03/08, M.D.: Extent of injury was skin, eyes, epithelium layering the parts of the eye including conjunctiva, endothelial cells covering the lining of the GI tract most notably esophagus and lungs.

01/19/09, M.D.: Symbicort, Spiriva, triamterene, Skelaxin, Norco, Kadian, Ultram, Cymbalta, Chantix, Serax were not appropriate while Restasis, nasal saline mist, Nexium, Lyrica, Lasix, levothyroxine, terazosin, lactulose, corticosteroid injections and oral medications were appropriate.

08/07/09, M.D.: Diagnosis – Chronic glaucoma of unknown type, presbyopia and hyperopic astigmatism. Opinions: Current eye complaints were not related. Causal relation to the original injury of xx/xx/xx cannot be established since there were no medical records for follow the eye complaints back to 1994.

10/01/09, Dr.: Exam: Visual acuity right eye 20/100 uncorrected best corrected 20/30. Left eye 20/100 at 6 feet. Refraction by right eye +1.50+1.75 x 180. Left eye -0.5 +1.25 x180. **Diagnosis:** Toxic cortical cataracts in each eye, not age related type cataract, macular degeneration dry type, dry eye syndrome and pinguecula of conjunctiva of both eyes. **Opinions:** Current eye complaints were related to the original injury of. The patient had advanced cataract that was inconsistent with the normal type of cataract developed with age. The current eye complaints of decreased and blurred vision, difficulty functioning or having difficulty with activities of daily living (ADLs) were related to original injury.

DIAGNOSTIC STUDIES:

12/02/94, Chest x-rays: Small opacities in both lower thirds of the lung fields suggestive of dust exposure.

12/12/94, Video esophagogram: Small left lateral pharyngeal diverticulum, small esophageal hiatus hernia. Occasional secondary and tertiary contractions in the thoracic esophagus.

03/15/95, Chest x-rays: Increased interstitial pattern, pleural effusions in right costophrenic sulcus, and degenerative spurs.

08/10/04, MRI right knee: Degenerative undersurface tear body of medial meniscus with mild degenerative edge tearing, degenerative tear of the posterior central root of the medial meniscus, mild effusion, mild medial compartment chondromalacia with minimal changes in the patellofemoral compartment and lateral compartment.

2010: From January through July, Dr. refilled Restasis ,Lyrica, Genoptic, Nasacort, Synthroid, Ultram, Nexium, Phenergan, Norco, Symbicort, Spiriva, hydrochlorothiazide–triamterene, Lasix, Nexium, terazosin, Chantix and Maxair. The urine drug screen was positive for hydrocodone.

On March 30, 2010, Dr. saw the patient for decreased visual acuity in right eye with trouble seeing print on roadside while driving. Examination revealed pigmented large clumping in the right eye. Dr. assessed visually significant cataracts in both eyes, history of age-related macular degeneration (ARMD) in the right eye, presumed ocular histoplasmosis syndrome (POHS) in both eyes. He explained to the patient that he may not get a dramatic improvement due to his retinal pathology. But the patient wished to proceed with the surgery due to difficulty seeing the road signs at a distance. Dr. recommended proceeding with cataract removal with IOL implant in the right eye.

Per utilization review dated June 3, 2010, cataract removal and lens insertion to the right eye was denied with following rationale: *“The patient is status post left eye cataract removal and lens insertion. The submitted clinical information does not include current exam including the outcome of the left procedure. The exam note dated March 30, 2010, reports the patient is having difficulty seeing road signs while driving as well as complaining of itching and mattering. The preoperative visual acuity of the right eye is 20/80 and the left eye is 20/400 without correction. Current literature recommends cataract treatment by surgical removal of the lens when the cataract leads to visual impairment; however, as*

documentation is not provided regarding the patient's current visual acuity the submitted request is not recommended and not certified at his time."

Per reconsideration review dated June 22, 2010, cataract removal and lens insertion of the right eye was denied with following rationale: *"Missing results of first operation of cataract removal where the macula looked healthier than the right eye. Missing current data on what was the prognosis for the right cataract in the appearance of a macula that should have had an OCT prior to surgery to document severe macular edema or other macular pathology contraindicating surgery. The office record clearly indicates that these are elective procedures and the cataracts were mainly nuclear in appearance which should respond to changing of the eye glasses. No records indicate the eyeglass change was given to the right eye before the surgery proceeded. There is no medical necessity to remove the right eye cataract if the left eye was unsuccessful in obtaining 20/40 or better vision, since macular degeneration was very pronounced in the right eye and would probably unless OCT tells otherwise preop what was going to happen to the retinal pathology affecting the final vision with cataract removal."*

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

THE CONCERN, RELATING TO THE ABSENCE OF DOCUMENTATION OF VISUAL ACUITY, RETINAL STATUS, AND CATARACTS PRIOR TO THE INJURY IS PROBLEMATIC. THE CATARACTS, AS DESCRIBED (NUCLEAR), ARE A NORMAL AGING PROCESS AND ARE NOT RELATED TO THE CHEMICAL EXPOSURE AS DESCRIBED: THE CLAIMANT HAS A HISTORY OF PRESUMED OCULAR HISTOPLASMOSIS (POHS) AS NOTED IN THE RECORD. THIS IS ALSO NOT RELATED TO THE INJURY IN QUESTION. WHILE IT IS TRUE THAT CATARACT EXTRACTION WOULD BE A POTENTIAL BENEFIT EVEN WITH MACULAR DISEASE, THE DOCUMENTATION DOES NOT SUPPORT THE CATARACT AS BEING CAUSALLY RELATED TO THE INJURY AND THEREFORE, CATARACT SURGERY IN THIS CASE IS NOT COMPENSABLE.

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**