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Notice of Independent Review Decision

DATE OF REVIEW: December 5, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional 10 sessions of work hardening program

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

Doctor of Chiropractic with 17 years experience.

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

- Utilization reviews (10/18/11 – 11/07/11)
- Office visits (11/29/10 – 10/12/11)
- Diagnostics (01/31/11 – 10/11/11)
- Procedure (06/03/11)
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ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was lowering a desk chair when the leg on the chair broke causing her to fall on xx/xx/xx. She inverted her right ankle during the fall and felt immediate pain in her right ankle and foot.

2010: Initially, the patient sought care at where she was examined, x-rayed, and treated with anti-inflammatories, pain medications, injection and physical therapy (PT) without much improvement. Surgery was requested which was denied.

D.C., diagnosed right ankle internal derangement, tenosynovitis and plantar fasciitis. He referred the patient for further diagnostic studies.

M.D., a pain management physician, treated the patient with Ultram and discontinued Voltaren and naproxen.

2011: M.D., an orthopedic surgeon, noted right foot/ankle pain associated with numbness/tingling sensation radiating towards the knee. Examination revealed tenderness over the medial and lateral malleolus, limited range of motion (ROM), pain with inversion and eversion stress, tenderness over the plantar fascia and mild paresthesias in forefoot. X-rays were unremarkable. He diagnosed internal derangement (right foot and ankle) and plantar fasciitis (right foot). He continued oral anti-inflammatories and ordered further diagnostic studies.

A video electronystagmography (ENG) report did not reveal any evidence of peripheral or central vestibular dysfunction.

M.D., a pain management physician, diagnosed right ankle pain and tenosynovitis. He treated the patient with a right ankle joint block, Norco, Elavil, Valium, Zanaflex, Naprosyn, Ultram and Voltaren 1% gel.

X-rays of the right ankle revealed a 6-mm inferior calcaneal spur and a small spur at the insertion of Achilles tendon. X-rays of the right foot revealed a minimal hallux valgus with slight lateral deviation of the proximal phalanges of the first through fifth digit.

Magnetic resonance imaging (MRI) of the right foot revealed: (1) Thickening and inflammation of the plantar fascia with partial-thickness tear at the insertion on the inferior calcaneus. (2) Minimal osseous proliferation along the posterior calcaneus at the Achilles tendon insertion. (3) Tendinitis of the distal posterior tibial tendon at its insertion on the navicular bone.

MRI of the right ankle revealed: (1) Inflammation thickening and partial tear of the plantar fascia at its insertion on inferior calcaneus. (2) Evidence of tendinitis of the distal posterior tibial tendon at its insertion on the navicular bone.

Per DWC PLN-11, right ankle/foot plantar fasciitis was accepted as compensable whereas distal tarsal tunnel and right knee was denied.

Dr. treated the patient with naproxen. He recommended doing home exercise program (HEP), stretches, using orthotics and requested tertiary functional restoration program. Dr. also prescribed heel orthotics and recommended plantar fasciitis stretching.

M.D., performed a peer review and rendered the following opinions: (1) There were still problems with plantar fasciitis so continued management should still be pursued. (2) Appropriate plan of treatment included an injection followed by formal rigid non-removable casting and one time Medrol Dosepak in conjunction

with steroid injections and casting. Further MRI and bone scans, PT, occupational therapy (OT), work hardening, work conditioning and a pain program were not appropriate. Follow-up visits were appropriate during the casting periods every two to three weeks. (3) Formal casting should be performed for a minimum of four to five weeks after injection into and around the area of maximum area of tenderness at the origin of the plantar fascia.

M.D., performed an electromyography/nerve conduction velocity (EMG/NCV) study which revealed signs of neuropathy affecting the right peroneal motor nerve at the ankle. Dr. diagnosed Achilles tendonitis and noted the orthotic was providing the patient with significant relief.

In July, a functional capacity evaluation (FCE) placed the patient in light physical demand level (PDL) as against her job required PDL of heavy. The evaluator recommended a chronic pain management program (CPMP).

Dr. noted the patient was wearing her inserts for 10 hours per day and had little pain with initial work hardening sessions.

A behavioral health evaluation revealed the patient had undergone 10 sessions of work hardening program (WHP) with an increase in her physical tolerance and pain levels. She was diagnosed with chronic pain disorder and was recommended additional 10 sessions of WHP.

An updated FCE in September also revealed that the patient was still functioning at the light PDL. The evaluator recommended WHP.

A video ENG report revealed significant peripheral vestibular and cerebral dysfunction. Balance rehabilitation was indicated.

On October 12, 2011, Dr. noted the patient complained that the orthotics did not fit but one pair of her shoes. He reviewed proper removal of shoe insole to allow orthotic to fit in the shoes. The patient also reported increased pain with walking greater than 10 minutes and improvement of tolerance while in WHP. Naproxen and orthotics were continued and additional 10 sessions of WHP were requested.

On October 18, 2011, D.C., denied the request for 10 additional WHP sessions based on the following rationale: *"It is not clear that the claimant has responded to work hardening as expected. Her pain level appears increased (note: there are numerous levels stated) and psyche scores are either unchanged, equivocal or increased. Likewise, her PDL apparently remains the same at light. While daily treatment notes were found, I could not discover any comparative lifting, etc., data to evaluate that aspect of functional gains. Finally, it appears claimant's 10th work hardening session was on 8/22/11; it is not clear why there is a 3-week gap in requesting 10 more sessions. Pending clarification, request is recommended for non-certification at this time. ODG work hardening criteria (9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities."*

In a reconsideration collaborative report for medical necessity, Dr. opined the fluctuating pain levels reported were a reflection of the activities that increased her pain or offered her relief. The gap in treatment was due to the patient travelling for family reasons. She had recently completed an initial 10 sessions of work hardening and had displayed increased functional ability. Based on this response, an additional 10 sessions were requested to continue to improve functional abilities and physical tolerances.

On November 7, 2011, D.C., denied the appeal for 10 additional WHP sessions based on the following rationale: *"The claimant completed 10 sessions of work hardening in August 2011 with there being no documentation available for review that supports any clinical progress attained from those sessions. Typically there is a re-examination or FCE performed that would provider appropriate clinical information but there is no such information in the file. The attending provider indicates in September and again in October that the claimant was going to be put in an FRP with an initial evaluation for that program submitted, but there is no indication that it was completed. All data being used for the current request is 6-8 weeks old and there is no evaluation completed in the last 45 days to support the necessity of the request. In addition, the claimant is only taking OTC medication at this time. In review of these concerns, the lack of supporting data and in referencing ODG guidelines, the request for an additional 10 sessions of work hardening is not medically necessary."*

On November 10, 2011, ROM and manual muscle test was performed which revealed significant deficit in strength with complaints of severe ankle pain. The evaluator felt the patient would benefit from continuing in an active rehabilitation program to strengthen weakened muscles and improve ROM.

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

The Dictionary of Occupational Titles Volume I Fourth Edition, Revised 1991. Defines: 323.687-014 CLEANER, HOUSEKEEPING: STRENGTH: LIGHT

Cleans rooms and halls in commercial establishments, such as hotels, restaurants, clubs, beauty parlors, and dormitories, performing any combination of following duties: Sorts, counts, folds, marks, or carries linens. Makes beds. Replenishes supplies, such as drinking glasses and writing supplies. Checks wraps and renders personal assistance to patrons. Moves furniture, hangs drapes, and rolls carpets. Performs other duties as described under CLEANER (any industry) I Master Title. May be designated according to type of establishment cleaned as Beauty Parlor Cleaner (personal ser.); Motel Cleaner (hotel & rest.); or according to area cleaned as Sleeping Room Cleaner (hotel & rest.).

GOE: 05.12.18 STRENGTH: L GED: R1 M1 L1 SVP: 2 DLU: 86

All of the FCE results provided report a LIGHT PDL.

The records provided do not show any improvement in physical performance after the initial 10 work hardening sessions. A work hardening program is used when a patient requires a multi-disciplinary approach to a work injury. From the

records provided she is currently taking OTC medications, and appears to have minimal psychological overlay. ODG states:

“The need for work hardening is less clear for workers in sedentary or light demand work, since on the job conditioning could be equally effective, and an examination should demonstrate a gap between the current level of functional capacity and an achievable level of required job demands.”

Based on the facts that this claimant is at a light physical demand level on par with the DOT definition of her job description. She has not shown significant improvement in her physical status after the initial 10 work hardening sessions. ODG recommendations based on the need of a work hardening program for a light PDL type job as being less clear. The records provided reveal minimal complications to her case requiring a multi-disciplinary approach.

I uphold the original denial of services as being not medically necessary, nor supported by the documentation provided.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES