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Notice of Independent Review Decision

February 14, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional 12 PT sessions, three times a week for four weeks to the right knee

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

Certified, American Board of Orthopaedic Surgery

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 (12/17/13, 01/20/14)
- Office visits (xx/xx/xx – 01/13/14)
- Therapy sessions (05/24/13 – 12/21/13)
- Diagnostics (05/30/13 – 10/08/13)
- Utilization reviews (01/20/14)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is male who on xx/xx/xx, was walking when his right knee twisted as he stepped on gravel and caused buckets to splash up and burned his hands and forearms.

Per a Physician's progress noted dated xx/xx/xx, the patient tripped and splashed on his hand and wrists. He suffered < 5 % third degree total body surface area (TBSA) burn. The handwritten reports are illegible.

On April 24, 2013, evaluated the patient for bilateral hands, forearms, and right knee injury. noted the patient had to have skin graft from right thigh. He was utilizing hydrocodone, Lyrica, Flexeril, Phenergan and lisinopril. The patient had a 5% TBSA burn. Diagnoses were status post third degree burn to the bilateral forearms and fingers status post skin grafting from the right thigh. The patient was to continue medications per the burn specialist. The patient was not working. recommended follow-up with burn specialist. The handwritten records are illegible.

On May 24, 2013, evaluated the patient for injury to the bilateral hands, forearms, and right knee. The patient reported that his knee would swell. He stated that after driving he had tried to stretch the knees, but it hurt if he pushed on them. He had pain in the left hand. He had tried to do the hand exercises. His pain increased with movements and with use. recommended continuing medications per the burn specialist. He ordered magnetic resonance imaging (MRI) of the right knee.

From May 24, 2013, through August 7, 2013, the patient attended 23 sessions of physical therapy (PT) consisting of interferential current, therapeutic exercises, therapeutic activities and neuromuscular re-education.

On May 30, 2013, MRI of the right knee showed grade I medial collateral ligament (MCL) sprain, prominent prepatellar subcutaneous edema with mild distal quadriceps and proximal patellar tendinosis, bilateral meniscal myxoid degeneration with superior articular surface fraying of the posterior horn lateral meniscus, small joint effusion and mild tricompartmental chondromalacia.

On June 5, 2013, the patient reported that his right knee was in a lot of pain. He felt worse sometimes on putting pressure on it and had a feeling of buckling or giving out. He reported that bending and straightening his right knee would hurt. He reported that his bilateral hands and forearms were healing well, but were sore. Examination of the right knee showed pain with flexion/extension. It was noted that the right knee would buckle while walking. He had pain to moderate palpation of the right knee. prescribed hinged right knee brace and recommended continuing medications and using crutches.

On July 8, 2013, the patient reported feeling an achy pain that would come and go and sharp pain with movement of the right knee. His bilateral arms had some spurs that were still sore, but he reported that they were healing. His left hand (palm) area was still sore. recommended continuing medications and PT.

On August 5, 2013, evaluated the patient for right knee complaints. The patient reported that with therapy, his right knee would loosen up and he was not feeling much pain, but as soon as he would get back home, the right knee would stiffen

up. The patient had bilateral forearm pain, but left forearm had a little more pain and was tender to touch. recommended continuing medications, right hinged knee brace, keeping clinic appointment and ordered MRI of the right knee for possible anterior cruciate ligament (ACL) tear.

On August 19, 2013, MR arthrogram of the right knee was performed which showed radial tear in the posterior horn medial meniscus with truncation.

On August 19, 2013, x-rays of bilateral orbits showed no radiopaque foreign body.

On September 5, 2013, noted that the patient had pain on standing, with movement, while twisting or turning and on trying to work without knee brace. He felt like falling out of place. His bilateral forearms had more pain down the middle of burns. He had got wrist compressors about one month ago. He was utilizing hydrocodone, Lyrica, Flexeril, Phenergan and lisinopril. The patient reported that right knee brace would help. It hurts to extend his right leg. Diagnosis was right knee grade I MCL sprain, proximal patellar tendinosis, right posterior horn medial meniscus tear, right meniscal myxoid degeneration with superior articular surface fraying of posterior horn of lateral meniscus. recommended continuing medication keeping burn clinic appointment and referred the patient to an orthopedic surgeon.

On September 13, 2013, evaluated the patient for right knee injury. The patient complained of sharp pain with any twisting activity, difficulty driving and pain with trying to get out of the car. His pain was located at the medial aspect of the right knee. He had pain with weightbearing and movements. He had attended 23 PT sessions and was taking ibuprofen. He was off work due to his burn injuries. Examination of the right knee showed tenderness to palpation at the medial joint line, positive McMurray's, limited range of motion (ROM) and pain with movement and weightbearing. There was hardly any crepitus on motion. The patient did limp on ambulation. discussed the MRI scan findings. The patient was given prescription for Norco. He was encouraged to go ahead with a right knee examination under anesthesia (EUA), arthroscopy and excision of meniscus tear.

On September 30, 2013, discussed surgery. The patient was scheduled for surgery on October 8, 2013. The patient was given prescription for Norco.

On October 1, 2013, the patient underwent various laboratory workup and urinalysis.

On October 1, 2013, x-rays of the chest showed stable prominence of ascending aorta. There were degenerative changes of the left humeral head which was only partially included.

On October 7, 2013, noted that the patient was going to have right knee surgery. The patient was to keep burn clinic appointment and continue medications.

On October 8, 2013, performed right knee EUA, arthroscopy and excision of tears of medial meniscus. Postoperatively, the patient was given crutch training and PT. He was also given referral for PT.

On October 9, 2013, noted that the wounds were benign. The patient moved his toes well. There was calf tenderness or ankle edema. The patient's Hemovac was removed. His wounds were cleaned and redressed. The patient was referred to therapy. placed the patient on appropriate work restrictions.

From October 10, 2013, through December 16, 2013, the patient attended 24 sessions of postoperative PT consisting of moist hot pack, inferential current (IFC), therapeutic activities, therapeutic exercises and neuromuscular re-education.

On October 21, 2013, noted that the patient was attending therapy. Per the PT note, the patient's flexion was 75 degrees with extension lack of 5 degrees. The patient was to continue therapy. He was maintained on restricted duty work.

On October 21, 2013, noted that bending of the right knee too far would increase pain. He had slight right knee pain, which was controlled with medications. He reported that PT was helping. recommended keeping appointments.

On November 4, 2013, noted that the patient was attending therapy. He recommended continuing PT, using crutches and maintained the patient on restricted duty.

On November 4, 2013, the patient stated that he had some tenderness in bilateral wrist area with pins and needle sensation and itching and sometimes he had cramps. He kept flexing to keep movement. He reported attending PT on knee and was seen and was to continue crutches. recommended continuing PT, brace, crutches and follow-up.

On November 19, 2013, noted that the patient had attended 15 sessions of therapy. His knee flexion was 118 degrees with full extension. He was unable to perform squatting activity. He was still using crutches for ambulation. His wound was benign. recommended continuing therapy and encouraged the patient to wean away from his crutches. He was maintained on restricted duty.

On November 19, 2013, the patient reported that his knee would swell sometimes. He had pain with pushing up; from sitting, standing and bending. The patient reported that his left wrist hurts mainly in the thumb area. His right wrist hurts on medial area especially with stretching and seemed to have some puffiness in his left wrist area. The patient was supposed to see on November 21, 2013. recommended continuing PT and keeping appointment.

On December 2, 2013, noted that the patient's flexion was 122 degrees with full extension as noted in the PT. He had completed 17 sessions of PT. He was not

using crutches for ambulation. recommended continuing therapy and maintained the patient on restricted duty.

On December 2, 2013, noted that the patient had some right knee soreness and slight weakness. The patient was using compressed gloves for wrist. It was noted that the patient was waiting for a call from a doctor so they could shot steroid on bilateral wrists. The patient had tenderness to touch of the bilateral wrists. It was noted that the patient saw the Burn specialist and was to get steroid injection in the wrist. recommended continuing PT and keeping follow-up with Burn specialist and. The patient was to continue medication as well.

On December 16, 2013, noted that the patient's flexion was at 120 and extension was full as noted on the PT note. There was no limp when the patient was ambulating. recommended continuing therapy and maintained the patient on restricted duty.

Per utilization review dated December 17, 2013, the request for additional 12 PT sessions, three times a week for four weeks to the right knee was denied with the following rationale: *"The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The mechanism of injury was a twisting injury. Medications were not provided within the medical records. Surgical history included a right knee arthroscopic meniscectomy on October 8, 2013, and excision and split thickness skin grafting to the bilateral upper extremities on April 16, 2013, as well as a shoulder surgery and left knee surgery. Diagnostic studies included an MRI of the right knee on May 30, 2013, with no signature present which revealed a grade I MCL sprain and prominent prepatellar subcutaneous edema with mild distal quadriceps and proximal patellar tendinosis as well as bilateral meniscal myxoid degeneration with a superior articular surface sprain of the posterior horn lateral meniscus and a small joint effusion. The MR of the right knee post-arthrogram dated August 19, 2013, revealed a posterior horn medial meniscal tear and no evidence of a high-grade cruciate or collateral ligament tear. Other therapies included physical therapy. The patient is a male with a reported date of injury on xx/xx/xx. The physical therapy initial evaluation dated October 10, 2013, noted that the patient had 75 degrees of flexion and -5 degrees of extension in the right knee. The patient had 2+/5 strength in the right knee. The physical therapy note dated November 26, 2013, noted that the patient had 122 degrees of flexion and 0 degrees of extension in the right knee. The provider noted that the patient had improved knee strength. The Official Disability Guidelines recommend 12 sessions of physical therapy over 12 weeks after a meniscectomy. Within the provided documentation, it appeared that the patient attended at least 22 sessions of physical therapy postoperatively. Within the provided documentation, there are no exceptional factors noted. The request for 12 additional sessions of physical therapy for the right knee would exceed the guideline recommendations. Within the provided documentation, it did not appear that the patient had significant objective functional deficits that would demonstrate the patient's need for physical therapy at this time. As such, the request for an additional 12 physical therapy visits at three times a week times four weeks is non-certified."*

On December 18, 2013, the patient underwent PT. The patient reported that he was still having a clicking sensation with toe off when walking. His pain level was 3/10 with current activity. The patient was treated with moist hot pack/ IFC, therapeutic activities and therapeutic exercises. He was instructed on home exercise program (HEP). It was noted that the patient had improved ROM and strength of the right knee. There was less knee muscle guarding and spasm with pain rated at 3/10 with activity and flexion. The patient walked with less protected gait with less limp and had improving endurance. The patient was recommended to continue with plan of care progressing towards stated goals set by the supervising PT.

On December 21, 2013, the patient underwent PT. The patient reported that he was walking better with less pain and stiffness. He reported that he was able to stand for longer periods of time. The patient continued complaining but objective signs were improving with less pain, 4/10 with current activity. The patient reported improvement in symptoms and improved function since starting therapy. His knee active ROM had improved along with dynamic stabilization. His core strength had also improved.

On December 30, 2013, noted that the PT request had been denied once and an appeal had been filled. The patient reported that his last therapy was in December 23, 2013. ROM was flexion to 120 degrees and with full extension. recommended continuing therapy. The patient was on appropriate work restrictions of no climbing stair/ladders, no kneeling/squatting, no bending/stooping, not performing any lifting/carrying over 20 pounds and desk work only.

2014: On January 3, 2014, noted that the patient had low level of pain while sitting, but when he climbed ladders he had increasing in pain. His bilateral wrists had tenderness. It was noted that more therapy was denied and would try work conditioning. recommended continuing medications, PT, follow-up with Burn specialist as scheduled and following up.

On January 13, 2014, noted that there was a note from the patient's therapy stating that they were waiting determination from the adjuster to proceed with more therapy. They have not yet heard if there was an adverse determination or an approval. Examination showed wounds to be benign. The patient moved his toe well. There was no calf tenderness or ankle edema. Extension was full and flexion was to 120 degrees. The patient was not using crutches for ambulation. There was no limp when ambulating. recommended continuing therapy and follow-up in two weeks. The patient was maintained on appropriate work restrictions.

Per reconsideration review dated January 20, 2014, the request for an additional 12 PT visits at three times a week times four weeks was denied with the following rationale: *"This is an appeal of an additional 12 physical therapy sessions, three times a week for four weeks to the right knee. The claimant is a male, who was*

injured on xx/xx/xx, in a fall. The claimant was diagnosed with a tear of the medial meniscus status post surgery. An MRI documented a meniscal tear and the claimant went on to a partial meniscectomy on October 8, 2013. Treatment included 23 physical therapy sessions postoperatively with continued improvement with mobility with stiffness and decreased pain. An evaluation on November 22, 2013, documented third degree burns over the bilateral hand and forearm. Medications included Lyrica, hydroxyzine, Flexeril, Naprelan, lisinopril, and unspecified narcotic medications. There were scars over the distal and medial wrist with moderate hypertrophy and tenderness. Healed wounds were noted with hyperpigmented scars and normal range of motion in the extremity. Lyrica and Atarax were prescribed on that date. There was full range of motion noted with no deficits documented. There was a previous non-certification for Kenalog scar injections and was currently participating in a home exercise program. Additional physical therapy was recommended. This is a non-certification of an appeal of an additional 12 physical therapy sessions, three times a week for four weeks to the right knee. The previous non-certification on December 17, 2013, was due to lack of significant deficits on physical examination. The previous non-certification is supported. Additional records included a progress note from physical therapy on December 13, 2013, documented pain of 0-3/10 on a visual analog scale but 5/10 at the worst. There was right knee flexion of 120-135 degrees, extension 0, and right knee muscle guarding with spasm. The pain was 0-1/10 at rest and 3/10 on a visual analog scale with activity. The claimant has had 21 or 22 sessions of physical therapy to date. The claimant has functional range of motion with no significant subjective reports of pain or weakness. The guidelines would support 12 physical therapy sessions over 12 weeks for the postoperative treatment of a meniscal repair. The request for an appeal of an additional 12 physical therapy sessions, three times a week for four weeks to the right knee is not certified.”

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

The determination of non-certification for 12 additional PT sessions appears to have been determined appropriately, in accord with ODG criteria. It does not appear that the requesting clinician provided any substantial objective clinical or evidence-based documentation to support the rationale for the request, outside of ODG criteria.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES