

MATUTECH, INC.

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Amended

December 5, 2006

December 4, 2006

Texas Department of Insurance
Division of Worker's Compensation
Fax: (512) 804-4871

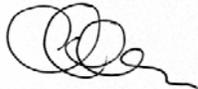
Re: Medical Dispute Resolution
MDR Tracking #: M2-07-0255-01
DWC#: _____
Injured Employee: _____
DOI: _____
IRO#: IRO5317

Matutech, Inc. has performed an Independent review of the medical records of the above-named case to determine medical necessity. In performing this review, Matutech reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

Matutech certifies that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were obtained from San Antonio Spine and Rehab, Patrick Hartsell, M.D., and Downs Attorney. The Independent review was performed by a matched peer with the treating health care provider. This case was reviewed by the physician who is licensed in chiropractics and is currently on the DWC Approved Doctors List.

Sincerely,



John Kasperbauer
Matutech, Inc.

REVIEWER'S REPORT

Information provided for review:

Request for Independent Review

Information provided by San Antonio Spine and Rehab:

Office notes (05/04/06 – 10/02/06)
Radiodiagnostic study (06/23/06)
Procedure note (06/28/06)
Therapy notes (06/02/06 – 06/23/06)

Information provided by Patrick Hartsell, M.D.:

Office notes (07/20/05 – 09/14/06)
Procedure notes (07/21/05 – 06/28/06)
Radiodiagnostic study (06/28/06)
Therapy notes (07/12/05 - 12/13/05)
Designated doctor evaluation (01/31/06)
FCE (01/09/06)

Information provided by Downs Attorney:

Office notes (07/20/05 – 10/13/06)
Radiodiagnostic study (07/20/05 – 06/26/06)
Procedure notes (07/20/05 – 06/28/06)
Therapy notes (10/13/05 – 06/02/06)
FCE (01/09/06)
Medical review (01/31/06)

Clinical History:

This 56-year-old male had a sudden onset of left leg and calf pain while carrying a fiberglass ladder.

Patrick Hartsell, M.D., evaluated the patient for complaints of left leg pain radiating behind the knee to the calf and foot. Dr. Hartsell noted the following: *The patient had a history of intermittent claudication of the left leg and was evaluated by an orthopedic surgeon who had prescribed Vicodin. Dr. Palomera had diagnosed left popliteal artery aneurysm of 6 cm in diameter and had recommended an ultrasound for possible Baker's cyst.* History was positive for degenerative disc disease (DDD). Computerized tomography (CT) angiogram showed a left popliteal artery aneurysm of 6 cm in diameter with inflammation in the surrounding soft tissues. Dr. Hartsell examined the patient and diagnosed symptomatic enlarging left popliteal artery aneurysm, hypertension, sleep apnea, and tobacco abuse. He strongly recommended admitting the patient to St. Lukes Baptist. Ultrasound of the left lower extremity revealed no Baker's cyst, but a 6.3 x 4.3 x 6.5 cm left popliteal artery aneurysm with a large amount of thrombus. On July 21, 2005,

Dr. Hartsell performed left femoral to below-knee popliteal artery bypass graft with reverse greater saphenous vein, and left popliteal artery aneurysm ligation. Postoperatively, Vicodin patch, Ambien, Wellbutrin, tramadol, and Vicodin were prescribed. Physical therapy (PT) was initiated. From October 13, 2005, through June 23, 2006, the patient attended 12 sessions of PT consisting of electrical stimulation, ultrasound, massage, joint mobilization, therapeutic exercises, and aquatic therapy. Following a functional capacity evaluation (FCE), work conditioning was recommended. David Savage, M.D., assessed maximum medical improvement (MMI) as of January 31, 2006, and assigned whole person impairment (WPI) of 10%. J. L. Eaves, D.C., noted exacerbation of left knee pain and assessed internal derangement of the left knee, muscular deconditioning, knee sprain/strain, myalgia/myositis, and postsurgical status. C. P. Garcia, M.D., assessed strain of the left gastrocnemius and lower thoracic and lumbar strain. He recommended 12 sessions of PT with home treatment consisting of hot/cold packs, analgesic creams, and mild exercises. Magnetic resonance imaging (MRI) of the left knee revealed: (1) A 4.0 x 4.0 x 3.0 cm abnormal soft tissue mass lying in the popliteal space deep to the popliteal artery and vein. (2) Unstable horizontal cleavage tear through the posterior horn and body of the medial meniscus. (3) A mild joint effusion. (4) DDD of the patellofemoral joint.

In June, Dr. Hartsell performed iliac angiography with bilateral lower extremity selective runoff. On June 28, 2006, he performed re-do left femoral to tibio-peroneal artery bypass graft with reverse greater saphenous vein harvested from the left leg. Postoperatively, Lopressor, Niaspan, Spiriva, and Advair were prescribed along with a walker. In August, Dr. Eaves noted continued left knee complaints and calf pain. He recommended PT with therapeutic exercises, aquatic therapy, and mobilization techniques. A request for aquatic therapy/exercises was denied by the carrier as it had been determined that the healthcare services requested did not meet the established standards of medical necessity. A reconsideration request for aquatic therapy was denied as this was typically used to rehab an acute postsurgical patient who was unable to tolerate land-based rehab. In September, Dr. Garcia recommended a two sessions of postoperative aquatic therapy due to continued pain and weakness with difficulty in ambulation, and added Soma. Dr. Hartsell reviewed a Doppler test and noted satisfactory triphasic signals in both ankles. There were elevated velocities distally, but there was turbulent flow around the distal anastomosis but the outflow arteries were widely patent. Dr. Hartsell believed that this primarily was because of the anastomosis over the origin of the anterior tibial and the tibial peroneal trunk, which required observation. However, he stated that the patient was overall doing well and would return for a follow-up in three months.

In October, Dr. Eaves noted positive Apley's compression/distraction tests on the left indicating a musculoligamentous injury. McMurray's and valgus/varus stress tests were positive on the left. There was tenderness and myofascial trigger points and myospasms in the vastus medialis, semimembranosus, and semitendinosus on the left. VMO on the left appeared considerably atrophied. Dr. Eaves felt aquatic PT was medically necessary. He allowed the patient to return to light duty.

Per attorney's letter, the aquatic therapy request was denied as the patient had not had surgery related to a ligament tear or meniscal tear and he had not complained to his surgeon about any postsurgical knee pain, and only a home exercise program (HEP) would suffice.

Disputed Services:

Twelve sessions of physical therapy (97113, G0283, 97140)

Explanation of Findings:

It appears that the employee began physical therapy at Warm Springs on 10/13/2005 due to swelling and muscle weakness. Physical therapy consisted of aquatic therapy, therapeutic activities, therapeutic exercises, gait training, and manual therapy. The functional capacity evaluation of 01/09/2006 reported the employee was capable of the medium physical demand level. The findings were questionable in that the arm lift was 54 pounds and high near lift was 20 pounds. The high near lift is easier and should be about 30% greater than the arm lift. The designated doctor certified the employee was at maximum medical improvement on 01/31/2006 and further material recovery as related to the ____ incident was not anticipated. The designated doctor indicated that he questioned the claimant's condition as truly work related. The impairment awarded was for a vascular disorder and not a condition related to the knee. The diagnoses from Jason Eaves, DC of internal derangement of the knee, knee strain/sprain, and lower thoracic/lumbar strain are not supported as related to the compensable injury of ____.

Intensive physical therapy was provided from 06/02/2006 through 06/23/2006 for 10 sessions. Despite the treatment, further vascular surgery was necessary to open an occlusion of the bypass graft that was provided originally as related to the compensable injury. Multiple requests for aquatic therapy were submitted from the provider.

Conclusion/Decision To Uphold, Overturn or Partially Uphold/Overturn denial:

Uphold decision to deny the requested treatment.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

The designated doctor certified the employee at maximum medical improvement on 01/31/2006 for the compensable diagnosis of peripheral vascular disorder. There was no compensable injury to the knee joint capsule, ligaments, or menisci established as related to the ____ event. In addition, there has been no significant instability or surgical procedure to the knee joint capsule, ligaments, or menisci that would support the need for the requested procedures (97113, G0283, 97140). Medically necessary is defined as the shortest, least expensive, or least intensive level of treatment, care, or service rendered to the extent required to diagnose or treat the compensable injury. The requested physical therapy is much too intensive in this case for this claimant. The previous trials of physical therapy in the records have not proven to be therapeutically beneficial to support more of the same.

The physician providing this review is a doctor of chiropractic. The reviewer is national board certified in chiropractic. The reviewer has been in active practice for 22 years.

Matutech is forwarding this decision by mail and in the case of time sensitive matters by facsimile a copy of this finding to the provider of records, payer and/or URA, patient and the Texas Department of Insurance.

Matutech retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by Matutech clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the Utilization Review Accreditation Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by Matutech represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to Matutech for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Matutech assumes no liability for the opinions of its contracted physicians and/or clinician advisors the health plan, organization or other party authorizing this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision, the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.