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Notice of Independent Review Decision Addendum

DATE OF ADDENDUM: APRIL 6, 2010

DATE OF ORIGINAL REVIEW: APRIL 2, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical performance evaluation (97750 6 units) and PT evaluation (97001 1 unit)

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

Fellow American Academy of Physical Medicine and Rehabilitation

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

TDI

- Utilization reviews (02/25/10 & 03/10/10)

ACE

- Office visits (06/02/07 – 02/05/10)
- Diagnostics (08/16/07 – 08/20/07)
- FCE (12/02/09)
- Procedures (08/14/09)
- WHP (11/23/09)
- Utilization reviews (02/25/10 & 03/10/10)

Dr.

- Office visits (02/05/10)
- Utilization reviews (02/25/10 & 03/10/10)

ODG have been utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who injured multiple body parts on **xx/xx/xx**, when she passed out in the restroom due to heat exhaustion. She was taken via ambulance with complaints of headaches.

Magnetic resonance imaging (MRI) of the lumbar spine showed mild broad-based disc protrusion at L5-S1 with mild lateral recess stenosis from osteophytes and discs; diffuse disc bulging at L4-L5 with small posterior osteophytes and incidentally benign hemangioma at the L4 vertebral body. Electromyography/nerve conduction velocity (EMG/NCV) of the bilateral lower extremities was unremarkable.

In a peer review, M.D., noted the following treatment history: *In August 2006, the patient was seen by, physician's assistant, for complaints of left knee pain. Magnetic resonance imaging (MRI) of the left knee obtained showed no significant abnormalities. She underwent arthroscopic left knee surgery in October 2006. She had persistent complaints of low back pain and underwent conservative treatment in the form of extensive supervised physical therapy (PT) and physical rehab program that concluded in January 2007, when she was said to have plateaued. The patient was treated with cyclobenzaprine, hydrocodone and naproxen. In August 2007, the patient underwent a designated doctor evaluation (DDE) by Dr. who placed her at maximum medical improvement (MMI) with whole person impairment (WPI) rating of 5%. She underwent lumbar epidural steroid injections (ESIs) x2 without significant symptomatic or functional improvement. She was given a cane for ambulation as she demonstrated limited lumbar motion and was requested to proceed with lumbar facet blocks. Dr. opined that based on the history of the patient having sustained injuries while working on June 10, 2006, and having had persistent complaints of low back pain, it appeared that on historical basis the current treatment was still related to the injury. No further treatment including office visits, chiropractic care, pain management, durable medical equipment (DME) or supervised physical rehab for lower back and left knee was indicated according to Official Disability Guidelines (ODG) criteria.*

The patient underwent a psychological evaluation and was diagnosed with chronic pain disorder associated with psychological features and general medical condition. The evaluator recommended participating in six sessions of individual counseling.

In August 2009, M.D., diagnosed chronic low back pain, lumbar facet syndrome and SI joint dysfunction and performed a left-sided facet block at L3, L4, and L5.

A functional capacity evaluation (FCE) performed in December 2009 placed the patient at a light physical demand level (PDL) versus heavy PDL. She had completed five sessions of work hardening program (WHP) and was recommended 10 more sessions.

In January 2010, M.D., noted the patient had completed a physical performance examination (PPE) that showed functional limitations.

On February 5, 2010, M.D., noted the patient could not complete 10 sessions of CPM due to migraine headaches. Her current complaints included shooting and stabbing pain in the lower back radiating into the right leg and muscle spasms with trouble sleeping due to pain. Ongoing medications included hydrocodone, Lidoderm patches, cyclobenzaprine, hydroxyzine and meloxicam. Examination revealed moderate/severe tenderness in the right L4 through S1 spinous process/paraspinals, mild/moderate tenderness in the right SI joint and positive Lasegue's test and straight leg raise (SLR) on the right. Dr. ordered x-rays of the lumbar spine, PPE and psychological evaluation.

On February 25, 2010, R.N., denied the request for PT evaluation and PPE with the following rationale: *"The history and documentation do not objectively support the request for a PPE or a PT evaluation in order to make a determination about continued treatment, especially if the request is because the old records are not available. The claimant has had extensive treatment to date and she has physical findings. Her condition is chronic and it is not clear how these evaluations are likely to significantly impact her future treatment. The medical necessity of the PPE and PT evaluation has not been clearly demonstrated. Recommend non-approval."*

On March 4, 2010, Dr. placed a request for reconsideration.

On March 10, 2010, a reconsideration request for PPE and PT evaluation was denied by, R.N. Rationale: *"Based upon the medical documentation presently available for review, medical necessity for this request is not established. The above-noted reference would support an expectation that the person could perform a proper nonsupervised rehabilitation regimen when and individual is this far removed from the onset of symptoms, particularly when past treatment has included an attempt at a comprehensive pain management program which would have included a psych evaluation. Additionally, medical necessity for a PPE would not appear to be established when it is documented that the FCE was reportedly accomplished in December 2009. The above-noted reference would not support a medical necessity for a repeat assessment of functional abilities when such an assessment was recently accomplished."*

On March 19, 2010, Dr. placed a second request for reconsideration of PPE and PT evaluation to document the patient's current subjective and objective findings as it related to her condition. He stated she had been already doing home exercise program (HEP) that would most likely benefit further from completing the full course of CPMP. While the ODG did not recommend therapies after the completion of CPMP or WHP, it did approve supervised exercise (therapies) up to two sessions to reinforce/update an existing HEP and as a means of managing chronic pain. He believed that the patient deserved reconsideration for the adverse determination and that a PT evaluation was medically necessary

and appropriate prior to continuing or enrolling in a multidisciplinary restoration program such as CPM.

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

After review of the records this individual has had therapy, work hardening and an FCE performed in December 2009. In addition, she has already had supervised exercises and further are not warranted. Dr. states she needs this prior to participating in a CPMP, which is assuming she would be approved for this when based on the records she would not meet the criteria for admission.

In conclusion, the request is not reasonable or recommended by ODG.

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

- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**