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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 16, 2010 AMENDED APRIL 19, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twelve sessions of physical therapy

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
Member of PASSOR

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

Travelers Indemnity

- Reviews (08/03/09)
- Office visits (09/25/09 – 12/15/09)
- Diagnostics (01/19/10)
- Therapy (11/16/09– 01/28/10)
- Utilization reviews (02/09/10 – 03/30/10)

TDI

- Utilization reviews (02/09/10 – 03/30/10)

ODG have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is male who sustained a work-related injury on xx/xx/xx. He fell and wrenched his right ankle when the cement mixer he was in turned on.

On August 3, 2009, , D.P.M., a designated doctor, noted that a functional capacity evaluation (FCE) performed in August 2009 had allowed the patient to return to work with restrictions but the patient had not yet returned to work since the injury. Electrodiagnostic studies of the lower extremities were positive for polyneuropathy and history was significant for diabetes. The patient reported complaints of pain, numbness, pins/needles, tingling, burning and weakness in the right foot. He ambulated with a limp to the right side. On examination, there were poorly healed 1 cm x 1 cm scars at the back of the right heel, tenderness all around the calcaneus, positive Tinel's, decreased range of motion (ROM) of the right ankle and foot and decreased sensory/motor testing of the right medial plantar and lateral plantar nerves. Dr. diagnosed right fractured calcaneus, right tarsal tunnel, right plantar fasciitis and crush injury on the right. He opined the patient had not yet reached maximum medical improvement (MMI) as he felt the patient would benefit from injection to the heel (plantar fasciitis), orthotic devices, night splint and physical therapy (PT). If conservative treatment failed, then surgical treatment by a podiatrist could be considered.

M.D., saw the patient in a follow-up of right calcaneus fracture, which was treated conservatively. He had some hindfoot wounds, which was treated with wound VAC by a plastic surgeon and the wound had eventually healed. Examination revealed some decreased ROM at the subtalar joint with associated tenderness. Dr. prescribed Celebrex.

The patient underwent 22 sessions of PT including therapeutic procedures/exercises. Dr. gave prescription for orthotics and released him to light duty work.

Due to continued pain around the hindfoot severely limiting his activities, a computerized tomography (CT) scan of the right foot was obtained, which revealed deformity of the calcaneus consistent with healed calcaneal fracture and large bony protuberances projecting from the plantar aspect of the mid calcaneus.

In January 2010, M.D., performed a PT evaluation and recommended phase II active rehabilitation including neuromuscular re-education, activities to the lower limb, joint mobilization by passive stretching, manual therapy and therapeutic exercises.

On February 11, 2010, the request for 12 sessions of PT was denied by the carrier with the following rationale: *"The patient sustained an injury over one year ago and was diagnosed with a right calcaneus fracture and hindfoot ulcer status post debridement on April 6, 2009. He had been approved for 30 PT visits since injury, but no progress reports were provided to objectively document functioning or progress with these visits. He currently reports a right foot pain increased with all weightbearing. The PT evaluation report dated January 28, 2010, indicates objective findings related to the left foot while the injury is on the right foot. This request is for additional 12 visits of PT. The requested number of visits exceeds the recommendations set forth by guidelines. With more than substantial number of therapy visits provided, the patient should have been fully progressed into an independent exercise program at this time. Compliance with home exercises must be reviewed. Furthermore, objective documentation response through VAS pain scales to other conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts was not provided in the medical records submitted. In the absence of exceptional indications, the medical necessity of the requested service has not been substantiated."*

On March 4, 2010, Dr. requested a reconsideration as the patient had not plateaued and continued to have functional deficits. He was making improvement with physical rehabilitation. The request was made to achieve the clinical MMI and help him return to work.

On March 15, 2010, the appeal for 12 PT sessions was denied with the following rationale: *“The mechanism of injury was not provided. He sustained a right calcaneus fracture and hindfoot ulcers status debridement on April 6, 2009. He has been approved for 13 PT visits since the injury, but no progress reports or response was provided. Medical documentation dated March 4, 2010, would appear to indicate that the patient was presently not a participant in any type of work activities. It is not documented if light duty work activities are available to the patient. He was seen on follow-up with an unspecified date for increased pain and discomfort of the right ankle. On examination, the right hindfoot had no significant widening or deformities and has healed. He has good ROM to ankle. Based upon the medical documentation presently available for review, medical necessity for the specific request is not established. For the described medical situation, the above-noted reference would support an expectation that the patient could perform a proper non-supervised rehabilitation regimen when the patient is this far removed from the onset of symptoms and when an individual has received the amount of services previously provided. As a result, at the present time, medical necessity for this specific request is not established per criteria set forth by the above-noted reference. Recommend non-approval.”*

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

BASED ON THE DOCUMENTATION REVIEWED THE DECISION IS UPHELD TO DENY FURTHER FORMALIZED THERAPY. THE PATIENT IS STATUS POST PRIOR APPROVAL OF 30 SESSIONS OF FORMALIZED THERAPY. THE ADDITIONAL REQUESTED FORMALIZED THERAPY FAR EXCEEDS THE ODG GUIDELINES FOR HIS INJURY TO THE ANKLE. HE HAS UNDERGONE EXTENSIVE FORMALIZED INSTRUCTION WITH STRENGTH, ENDURANCE AND RANGE OF MOTION EXERCISES FOR THE ANKLE AND FOR THE INJURY. AT THIS JUNCTURE OF TREATMENT HE SHOULD BE WELL VERSED REGARDING INDEPENDENT USE OF A THERAPEUTIC HOME EXERCISE PROGRAM TO ALLOW CONTINUED IMPROVEMENT IN RANGE OF MOTION, STRENGTH AND ENDURANCE. TREATING PHYSICIAN HAS REPORTED EVEN THOUGH HIS CALCANEAL FRACTURE HAS HEALED HE MAY EXPERIENCE ONGOING SUBJECTIVE COMPLAINTS OF PAIN. THERE IS NO INDICATION THAT FURTHER FORMALIZED THERAPY WOULD IMPROVE HIS LEVEL OF PAIN BASED UPON THIS INFORMATION BY HIS TREATING PHYSICIAN. THERE IS NO INDICATION FROM THE MEDICAL RECORDS REVIEWS THAT HE WOULD NOT HAVE THE CAPACITY TO PERFORM INDEPENDENT THERAPEUTIC EXERCISES FOR THE RIGHT ANKLE AND FOOT BASED UPON DOCUMENTATION REVIEWED. THERE IS NO REPORT THAT HE HAS BEEN COMPLIANT WITH DAILY USE OF A THERAPEUTIC HOME EXERCISE PROGRAM TO IMPROVE STENGTH, ENDURANCE AND CONDITIONING OF THE ANKLE AND FOOT INJURY.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES