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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 22 home health physical therapy visits, 2 evaluations, and 20 visits related to the lower back injury

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Family Practice

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XX whose date of injury is XX. The mechanism of injury is detailed as a penetrating injury to the low back secondary to a XX exploding. The patient has a diagnosis of hemorrhage, not elsewhere classified. PT/OT progress note dated XX indicates that the patient had been performing self-care and self-care mobility with improved performance. The patient was adequately able to perform self-care and had met all short-term goals. Physical examination revealed a penetrating wound to the back. Home health order dated XX indicates that the patient has active bleeding from within, status post bleeding control with figure of 8 suture ligation of the bleeding vessel and wound packing with quick clot. Wound vac was placed, to be changed Q3days. Current medications are XX, XX, XX, XX,XX, XX,XX, XX and XX

Initial request was non-certified noting that the Official Disability Guidelines state that home health services are recommended on a short-term basis following major surgical procedures or inpatient hospitalization, to prevent hospitalization, or to provider longer-term in-home medical care and domestic care services for those whose condition is such that they would otherwise require inpatient care. Justification for medical necessity include objective deficits in function and the specific activities precluded by such deficits, the expected kinds of services that will be required, with the exception of tasks and services that can be performed free of charge by the worker's spouse or other household member, with an estimate of the duration and frequency of such services. In this case however, it was noted that

the patient had been performing self-care and self-care mobility with improved performance. The patient noted in long sitting position able to perform various reaching movements with little to no difficulty. It was additionally noted that the patient was adequately able to perform self-care and had met all short-term goals. Additionally, there was a lack of documentation indicating the patient would be unable to secure transportation to and from an outpatient therapy center to sufficiently warrant this request. As such, the request XX, 2 Evaluations and 20 visits, related to low back injury is not medically necessary. The denial was upheld on appeal dated XX noting that the clinical documentation submitted for review does indicate that the patient was evaluated on XX by physical therapy and occupational therapy services and it was documented that the patient was able to perform self-care activities and all short-term goals were met. Although the patient does have limited mobility, there is no documentation that the patient is unable to attend outpatient services. Additionally, the request for 20 sessions would be considered excessive, as the documentation specifically identifies that the patient should progress to independent ambulation quickly. As such, the risk consideration for home health physical therapy services, 2 evaluations in 20 visits (20151) related to low back injury is not medically necessary.

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

Based on the clinical information provided, the request for 22 home health physical therapy visits, 2 evaluations, and 20 visits related to the lower back injury is not recommended as medically necessary, and the previous non-certifications are upheld. The Official Disability Guidelines note that home health services are recommended on a short-term basis following major surgical procedures or in-patient hospitalization, to prevent hospitalization, or to provide longer-term in-home medical care and domestic care services for those whose condition is such that they would otherwise require inpatient care. The submitted clinical records fail to establish that the patient's condition is such that XX would otherwise require inpatient care. The request for 20 sessions is excessive and does not allow for adequate interim follow up to assess the patient's response to treatment. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

IRO REVIEWER REPORT TEMPLATE -WC

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

Official Disability Guidelines Treatment Index, 23nd edition online, 2018-Pain Chapter updated 06/19/18

Home health services

Recommended on a short-term basis following major surgical procedures or in-patient hospitalization, to prevent hospitalization, or to provide longer-term in-home medical care and domestic care services for those whose condition is such that they would otherwise require inpatient care.

See also Skilled nursing facility (SNF) care.

Justification for medical necessity of Home health services requires documentation of:

(1) The medical condition that necessitates home health services, including objective deficits in function and the specific activities precluded by such deficits; &

(2) The expected kinds of services that will be required, with the exception of tasks and services that can be performed free of charge by the worker's spouse or other household member, with an estimate of the duration and frequency of such services; &

(3) The level of expertise and/or professional qualification or licensure required to provide the services. Homebound is defined as "confined to the home". To be homebound means:

- The individual has trouble leaving the home without help (e.g., using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of the occupational illness or injury OR Leaving the home isn't recommended because of the occupational illness or injury AND

- The individual is normally unable to leave home and leaving home is a major effort. (CMS, 2014)

(4) Evaluation of the medical necessity of Home Health Care services is made on a case-by-case basis. For Home Health Care extending beyond a period of 60 days, the physician's treatment plan should include referral for an in-home evaluation by a Home Health Care Agency Registered Nurse, Physical Therapist, Occupational Therapist, or other qualified professional certified by the Centers for Medicare and Medicaid in the assessment of activities of daily living to assess the appropriate scope, extent, and level of care for home health care services. (CMS, 2015) Personal care services and

domestic care services should not be covered when there are no skilled (licensed nurse or therapist) home health services being provided.

(5) The treating physician should periodically conduct re-assessments of the medical necessity of home health care services at intervals matched to the individual patient condition and needs, for example, 30, 60, 90, or 120 days. Such reassessments may include repeat evaluations in the home.

Home health care is the provision of medical and other health care services to the injured or ill person in their place of residence. Home health services include services deemed to be medically necessary for patients who are confined to the home (homebound) and who require: (1) Skilled care by a licensed medical professional for tasks including, but not limited to, administration of intravenous drugs, dressing changes, occupational therapy, physical therapy, and speech-language pathology services; with or without additionally requiring (2) Personal care services for tasks and assistance with activities of daily living that do not require skills of a medical professional, such as bowel and bladder care, feeding, bathing, dressing and transfer and assistance with administration of oral medications; and/or (3) Domestic care services such as shopping, cleaning, and laundry that the individual is no longer capable of performing due to the illness or injury that may also be medically necessary in addition to skilled and/or personal care services. Services described under (2) and (3) should be covered only when (1) is justified. An employer or their insurer shall not be liable for household tasks the injured worker's spouse or other member of the injured worker's household performed prior to the injury free of charge. (CMS, 2015) Domestic and personal care services do not require specialized training and do not need to be performed by a medical professional. (ACMQ, 2005) (Ellenbecker, 2008)

Office visits
Recommended as determined to be medically necessary.

Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also Telehealth.

Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical

office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines, such as opiates or certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible.

The ODG Utilization Review Advisor (UR Advisor), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the UR Advisor may serve as a “flag” to payers for possible evaluation; however, payers should not automatically deny payment for these if preauthorization has not been obtained. Note: The high-quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of “virtual visits” compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004)