

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** December 23, 2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical therapy comprising of therapeutic exercises (97110) and massage therapy (97124)

**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)

ODG have been utilized for denials.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx-year-old male who was injured on xx/xx/xx. The patient had a pulling in his shoulders with neck stiffness when lifting boxes repetitively onto a forklift.

**1991 – 1992:** The patient was treated with exercises, ice packs, and salsalate for neck and right shoulder pain and was released to light duty. Magnetic resonance imaging (MRI) of the right shoulder revealed mild intratendinous degeneration of the rotator cuff. X-rays and computerized tomography (CT) of the cervical spine were unremarkable. Electromyography/nerve conduction velocity (EMG/NCV) study of the right upper extremity demonstrated mild chronic re-innervation changes in the adductor digiti quinti probably secondary to focal trauma at wrist involving the ulnar nerve. MRI of the cervical spine revealed mild disc bulge at C3-C4, left slightly greater than right; and minimal posterior bulges at C5-C6 and C6-C7. The patient was treated with multiple sessions of physical therapy (PT) consisting of hot packs, massage, exercises, and ultrasound as well as trials of multiple medications and transcutaneous electrical nerve stimulation (TENS) unit. He returned to work but exertion caused exacerbation of his neck pain. His physician felt he possibly had cervical cord lesion or disc lesion with cord involvement and myositis syndrome. Repeat MRI of the cervical spine revealed minimal degenerative changes including minimal right C5-C6 right posterior protrusion. MRI of the thoracic spine showed mild scoliosis. He was placed at maximum medical improvement (MMI) with no permanent impairment

rating (IR) and was recommended return to work without restrictions. A designated doctor noted 5+ Waddell's signs and assigned 4% IR. Further PT was denied in July 1992; however the patient was maintained on medications. A neurosurgeon saw him for radicular pain and symptoms in right arm. Cervical myelogram was negative. CT revealed minimal central and slightly right-sided posterior disc bulge at C5-C6 resulting in minimal mass effect on the thecal sac. The patient was not felt to be a surgical candidate.

**1993 – 1995:** The patient had complaints of headache, neck pain, right arm pain, numbness in the right hand and arm, and chronic low back pain. MRI suggested central disc herniations at L4-L5 and L5-S1. He was treated with multiple medications, PT for neck, TENS unit, and thoracolumbosacral orthosis (TLSO) brace. EMG/NCV of right upper and lower extremity was unremarkable.

**1996 – 2000:** From 1996 through 1999, the patient was treated conservatively with medications for complaints of neck pain, headaches, decreased strength in the right arm, and lumbar pain. He participated in a functional capacity evaluation (FCE), but could not complete it due to pain. From April 1999, he came under the care of , D.O., who treated him with the following: cervical ESI x1; trigger point injections (TPIs) in the posterior right shoulder; nerve blocks at C6, C7, and C8 on the right x7, and right occipital nerve blocks x2. Multiple medications were tried along with soft tissue mobilization.

Ultrasound of the right shoulder revealed rotator cuff tendonitis. Ultrasound of the cervical spine revealed C3-C5 bilateral facet inflammation and spasm at C4-C6 bilaterally at the posterior cervical region. NCV study of the upper extremities revealed left C6, C7, and bilateral C8 radiculopathy. EMG study suggested a denervating process at C6 with two C6 muscles involving (biceps and brachioradialis). MRI of the cervical spine revealed a right paracentral protruding disc minimally effacing the thecal sac at C5-C6.

On December 13, 2000, the patient underwent brachial plexus neurolysis and decompression, middle scalenotomy, vascularized scalene fat flap reconstruction, suprascapular nerve neurolysis, trapezius tenotomy and fasciotomy, and division of the posterior branch of the supraclavicular nerve to the superior trapezius trigger point region. The postoperative diagnoses were right brachial plexus entrapment at the scalene muscle triangle region with development of trapezius myofascial pain syndrome as a sequelae of this entrapment.

**2001 – 2003:** Dr. maintained the patient on medications including muscle relaxants, narcotic pain medications, and sleep medications. She performed bilateral occipital nerve blocks x1 and right occipital nerve block x1. Another pain specialist assessed somatic dysfunction and osteoarthritis, and myofascial pain with trigger points, and treated the patient with indirect manipulative therapy. In a psychological evaluation, patient's Beck Depression Inventory – II (BDI-II) and Beck Anxiety Inventory – (BAI) scores were 23 and 26 respectively indicating significant depression and anxiety. He was diagnosed with pain disorder and was recommended chronic pain management program (CPMP). He participated in an FCE, but could not complete the test.

**2004 – 2005:** Dr. 's treatment included: bilateral occipital nerve blocks x5; multiple TPIs in the bilateral cervical paravertebral, right trapezius, right posterior

shoulder, and thoracic spine; multiple medications; and TENS unit.

In a required medical evaluation (RME), , M.D., noted the patient had undergone C3-C4 fusion in 2001. He assessed chronic pain syndrome and depression, anxiety, and somatization. After performing the FCE, he opined that the patient was capable of returning to work in sedentary position.

X-rays of the cervical spine revealed postoperative changes including anterior fusion with placement of plate and two screws at C4 and C6 levels. In 2005, the patient attended 20 sessions of CPMP. Thereafter, Dr. performed bilateral occipital nerve blocks x2, TPIs in the right trapezius, and T4-T6 regions, and right suprascapular nerve block. The patient was treated with Skelaxin, Mobic, Avinza, Sonata, Duragesic patch, OxyContin, Flexeril, Ambien, and Neurontin.

**2006 – 2007:** The patient's treatment included bilateral occipital nerve blocks x3, right suprascapular block x2, and Botox injections to the trapezius region x3. He received multiple medications including antidepressants, narcotic short-acting and long-acting pain medications, sleep medications, muscle relaxants, neuropathic medications, and pain injectables.

In December 2006, , D.O., performed a peer review and opined: (1) The current treatment was not appropriate and related to the original injury. (2) Majority of the treatment administered over the years could not be justified. (3) No further durable medical equipment (DME) and/or diagnostic testing would be considered medically necessary. (4) Continued use of medications was not reasonable and necessary and related to the original injury.

In a designated doctor evaluation (DDE) performed in March 2007, , D.O., opined as follows: The current symptoms/complaints were not related to the original injury. Based on current and very reasonable evidenced-based medicine, the patient was fully capable of and certainly should return to work. The extent of the compensable injury was cervical sprain/strain, and the injury had resolved years ago.

In a Contested Case Hearing (CCH), performed on June 19, 2007, following decision was given: *The compensable injury of August 29, 1991, does not include a C5-C6 disc bulge, headaches, or depression. The compensable injury of August 29, 1991, includes a right shoulder injury.*

In October 2007, Dr. performed another peer review and rendered the following opinions: (1) The current treatment (office visits and medications) were not appropriate and related to the compensable injury of cervical sprain/strain, and/or right shoulder sprain/strain. (2) No further care would be reasonable, medically necessary, and related to the compensable injury of xx/xx/xx. (3) No DME or additional diagnostic testing would be required. The patient had already had an extensive workup. (4) No medication at this point would be reasonable or necessary to treat the original event. The current symptoms were not related to the compensable injury.

**2008:** From January through October, there were multiple follow-ups with Dr. for right shoulder and neck pain. Her treatment included medications (Avinza, Lyrica, Flexeril, and Lorcet), Botox injections to the trapezius region x1, and massage therapy x6 sessions.

In September, Botox and occipital nerve blocks were denied, but the decision of denial was overturned by an independent review organization (IRO).

On November 10, 2008, Dr. requested eight sessions of therapeutic exercises and massage.

On November 14, 2008, , M.D., denied the request for the therapeutic exercises and massage with the following rationale: *“The documentation provided for review does not indicate the number of sessions of PT completed to date; objective, measurable, and sustained progress with previous PT; objective functional deficits; difficulty with activities of daily living or with job specific requirements; or objective functional goals to support the medical necessity of additional PT for this xxxx date of injury.”*

On November 25, 2008, Dr. refilled Lyrica, Flexeril, Lorcet, and Avinza, and noted the patient was doing home exercise program (HEP).

On December 3, 2008, , D.O., denied the appeal for therapeutic exercises and massage with the following rationale: *“Call placed to Dr. on December 2, 2008, at 4:45 pm and spoke with and requested call back tomorrow. I called again at 1:55 pm on December 3, 2008, and left another message with requesting that Dr. return to call. But no call back received by 3:50 pm. The claimant is treating for neck and shoulder pain. The employee has reported improved with massage in the past. The current request is for PT. There is no objective documentation to support that the employee has improved with past PT or massage therapy; for example: improved ROM of cervical spine and shoulder, decreased pain medications, increased work activities, improved VAS pain scale with PT. Therefore, there is no objective evidence of past benefit documented in the medical records supporting the statement that massage therapy helps pain sufficiently to continue PT or massage therapy for a xxxx injury with current diagnosis of neck sprain and shoulder pain. An independent home exercise program (HEP) could be considered instead. Official Disability Guidelines (ODG), WLDI 2008 only recommends continued therapy if there is documented evidence of benefit. The number of past massage therapy sessions, duration of relief is unknown. The studies for use of massage for shoulder pain are conflicting and there is little scientific evidence to support use of massage therapy for the neck.”*

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. BASED ON THE DOCUMENTATION AVAILABLE FOR MY REVIEW, REQUEST FOR THERAPY IS NOT REASONABLE OR SUPPORTED BY ODG. IF INJECTIONS WERE FOR THE COMPENSABLE INJURY ODG WILL ALLOW A SINGLE SESSION. HOWEVER, IT DOES NOT APPEAR RELATED AND THERAPY REQUEST SIGNIFICANTLY EXCEEDS RECOMMENDED.**

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

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