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Notice of Independent Review Decision

DATE OF REVIEW: August 12, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy three weeks for four weeks for neck

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

Certified, American Board of Orthopaedic Surgery

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

- Utilization reviews (07/06/09 – 07/27/09)
- Diagnostic (12/11/06)
- Office visits (07/11/08 – 06/30/09)
- Utilization reviews (07/06/09 – 07/27/09)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old male who slipped and fell while working on xx/xx/xx.

2006: In December, cervical myelogram followed by computerized tomography (CT) revealed spondylosis at C3-C4 with posterior bony ridging and spondylotic bulging of the annulus of 3-4 mm, mildly deforming the C4 ventral outlet; associated uncovertebral hypertrophy with moderate left foraminal encroachment and small degree of right foraminal encroachment with peripheral underfilling asymmetrically involving the left C4 nerve root sleeve; minimal bulging of the

annulus at C4-C5 with small degree of left foraminal encroachment due to spondylosis; and minimal foraminal encroachment at C5-C6.

2008: In July, the patient was evaluated by , M.D., for neck, shoulder/arm, low back, and mid back pain, and headaches. The patient had been treated with a transcutaneous electrical nerve stimulation (TENS) unit, medications, and cervical epidural steroid injections (ESIs). The patient felt his anxiety level had gone up due to pain. Dr. diagnosed occipital radiculitis. He prescribed Wellbutrin, Methadone, Soma, Topamax, and Maxalt. From September through December, the patient was evaluated on monthly basis by Dr. and was treated with medications. He recommended trigger point injections (TPIs), cervical ESIs, and right occipital nerve block. In December, Dr. noted the patient was status post occipital nerve block with 80% improvement. He noted increasing muscle spasms and recommended proceeding with a second occipital nerve block and TPIs and physical therapy (PT) evaluation.

2009: In January, the patient underwent right occipital nerve block with improvement in headaches. From February through June, there were regular follow-ups with Dr. who noted improvement in occipital neuralgia with the block. The patient complained of worsening low back pain. He had been treated with lumbar ESIs in the past with good results. Dr. recommended weaning the patient off methadone on his own and requested lumbar ESIs. For anxiety and depression, he prescribed Cymbalta and Opana ER. Later, he restarted Methadone as pain significantly worsened after decreasing it.

, M.D., evaluated the patient for headache and noted that he was treated with Botox injection for headache and was doing better. He prescribed Soma, methadone, Wellbutrin, Cymbalta and referred the patient for a psychological evaluation.

In June, , M.D., evaluated the patient for neck pain, worse by bending in the neck from side to side and then particular by moving the neck into extension. He noted the following treatment history: *The patient had undergone a cervical spine CT myelogram study, which was complicated by bacterial meningitis for which the patient was admitted to the hospital and was treated with intravenous (IV) antibiotics. He had attended chiropractic sessions 10 years ago had had not had any recent therapy.* The patient reported pain in the posterior cervical area to the right of the midline with radiation into the proximal shoulder girdle on the right with the pain traveling down the right hand affecting the ulnar side of the hand and the ulnar three digits. There was numbness and tingling in the same distribution. The patient reported weakness and clumsiness with the hands, deterioration of his handwriting skills, and difficulty executing fine motor skills. Dr. obtained x-rays of the cervical spine which were unremarkable. He assessed chronic neck pain associated with secondary deterioration of the C3-C4 motion segment and a 3-mm disc protrusion at C3-C4 with secondary motion segment deterioration. Dr. stated a new MRI could not be obtained because of the spinal cord stimulator (SCS) that had been placed. Also another CT myelogram could not be obtained as the patient had got bacterial meningitis from the last one. Dr. recommended PT as the first line of treatment with an emphasis on cervical isometric strengthening and upper extremity strengthening.

Per treatment history chart, from the date of injury through June 30, 2009, the patient was treated as follows: X-rays of the entire spine following the injury, treatment with extensive chiropractic therapy and PT from 1999 through September 2007, treatment by Dr.

Per utilization review dated July 6, 2009, request for PT three per week for four weeks, for a total 12 visits was denied with the following rationale: *“I have reviewed the clinical information submitted and the Official Disability Guidelines (ODG). The patient sustained injury on xx/xx/xx. In the latest medical note stated June 23, 2009, he complained of intractable neck pain radiating to the proximal shoulder on the right. The pain travels down the right hand affecting the ulnar side and ulnar three digits. He has numbness and tingling. There was associated weakness. However, the records submitted contained no clinical documentation on the complete physical examination of the affected body part, response to medication and other forms of conservative management, current functional status of the patient, as well as plans for patient’s participation in an active home exercise program (HEP). Although above guidelines recommended PT, it must be part of a more comprehensive treatment plan that was not shown in the documents provided. The documentation submitted and review of the guidelines do not support the medical necessity of the requested PT.”*

Per reconsideration review dated July 27, 2009, the evaluator noted that the patient had undergone the chiropractic care for approximately one year, SCS implant, and several occipital nerve blocks as well as multiple TPIs. He also had radiofrequency thermocoagulation of the greater occipital nerves bilaterally. There was evidence that the claimant had abnormal EMG. A cervical myelogram revealed a small degree of effacement of central subarachnoid space C3-C5 with subtle blunting asymmetry of the left C4-C5 nerve root sleeves. A request for PT three per week for four weeks was denied with following rationale: *“Records do not reflect the indication for ongoing formal therapy versus a home exercise program. The claimant has had extensive chiropractic care and PT.”*

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

The opinions of the two evaluators differ only in the rationale for denial. Either and both of the rationales have merit. There is no expectation that PT, in and of itself, will have any substantive effect on the chronic pain; and there is insufficient evidence that 12 sessions of PT as requested meets ODG criteria. The adverse determination should be upheld. Although PT is a “first line treatment,” that stage has been long since passed.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**