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Notice of Independent Review Decision

DATE OF REVIEW: July 20, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3 x week x 4 weeks (12 sessions) to the cervical spine (CPT codes #97110, #97140, and #G0283)

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

Board Certified, Diplomate American Board of Physical Medicine and Rehabilitation and Pain Medicine

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

TDI

- Utilization reviews (05/25/10, 06/15/10)

Liberty Mutual Group

- Office visits (02/19/09 – 06/10/10)
- Diagnostic studies (02/25/09 – 02/19/09)
- Utilization reviews (05/25/10, 06/15/10)

Dr.

- Diagnostic tests (02/05/09 - 05/19/10)
- Office visits (05/19/10 – 06/10/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his neck, arm, right shoulder, elbow and hand on xx/xx/xx, after constantly lifting heavy objects for long hours.

2008: On December 17, 2008, , PA-C, evaluated the patient and diagnosed cervical sprain/strain, right lateral epicondylitis of the elbow, contractures of the right thumb and status post partial meniscectomy of the right knee. He prescribed hydrocodone, ibuprofen, and Flexeril, and recommended injection to

the elbow and the thumb after obtaining an electromyography (EMG) of the upper extremities.

2009: In January, Mr. assessed cervical strain (rule out cervical disc disease due to radicular symptoms) and hypertension. Cyclobenzaprine was added and the patient was referred to his primary care physician (PCP) for hypertension workup.

Magnetic resonance imaging (MRI) of the cervical spine was obtained for severe neck pain. It revealed: (1) Reversal of the usual lordotic curvature and mild narrowing with diminished signal of the C4-C5 and C5-C6 discs. (2) At C4-C5 disc desiccation was noted with an annular disc bulge flattening the thecal sac. (3) The C5-C6 level revealed disc desiccation with a 3-mm subligamentous disc protrusion flattening the thecal sac.

M.D., performed an electromyography/nerve conduction velocity (EMG/NCV) study of the upper extremities for complaints of neck pain radiating into the right arm associated with intermittent tingling. The study revealed evidence of bilateral median sensory and motor neuropathy as well as findings consistent with bilateral acute and chronic C6 radiculopathy, more severe on the right side.

Mr. recommended a cortisone injection into the right shoulder and an epidural steroid injection (ESI) to the cervical spine.

D.O., performed a designated doctor evaluation (DDE) and placed the patient at clinical maximum medical improvement (MMI) as of March 25, 2009, with 0% whole person impairment (WPI) rating. The extent of the compensable injury was a cervical strain, while the shoulder complaints were referred from his cervical spine. His disability was a direct result of the work-related injury and he was able to return to work with restrictions.

M.D., pain management, diagnosed cervical radiculopathy, prescribed hydrocodone and Zanaflex and referred the patient for an orthopedic evaluation for the cervical spine.

2010: M.D., a pain management physician, noted the patient had been treated with pain medications and one epidural injection after which she developed a spinal headache. The patient had constant pressure and burning pain to the neck, which radiated down his right arm. He also admitted to have some swelling to the right arm with associated numbness and tingling to the right arm greater to the right hand. Dr. diagnosed cervical pain with radiculopathy, C4-C6 distribution, bulging discs, and flattened thecal sac, C5-C6 protrusion of thecal sac fragment; right shoulder pain with possible bursitis and sprain to paraspinous ligaments. He prescribed medications, recommended a series of cervical interspinous injections with trigger point injections (TPIs) and therapy three times a week for four weeks.

On May 25, 2010, D.O., denied the request for 12 visits of PT to the cervical spine over four weeks with the following rationale: *"PT is not medically necessary. The injury is 18 months old. The patient should be doing an active home exercise program (HEP) at this time. A request for 12 sessions exceeds*

Official Disability Guidelines (ODG) even for an acute injury. The electrical stimulation is considered an unproven therapy and is not indicated.”

On June 10, 2010, Dr. noted increased pain and discomfort across the neck, shoulder, and down the right arm to the hand and the fingers. The patient stated that the pain was moderate-to-severe and had not improved with conservative care including HEP and stretching program. Hydrocodone was helping with the pain, but not significantly and he had complaints of headaches on a daily basis that were related to the ongoing cervical pain. Dr. recommended a series of two cervical ESIs with TPI and rehabilitation program three times a week for the next four weeks. The goal was to improve the range of motion (ROM), decrease the pain and allow the patient to be much more functional. He further opined that regardless of the amount of time that had been since the injury, the patient still had pain and discomfort that was related to the injury. Therefore the patient should be allowed to undergo an appropriate rehabilitation program.

On June 14, 2010, M.D., denied the appeal for 12 visits of PT to the cervical spine based on the following rationale: *“The Official Disability Guidelines (ODG) support the recommendation of 12 sessions of PT over 10 weeks. The patient’s injury occurred on xx/xx/xx, and in the exam note dated June 10, 2010, it is reported the patient attended PT. However, treatment notes have not been provided for this review and reporting the frequency, duration or efficacy to treatment. Clinical information provided does not show any exceptional factors to preclude evidence-based guidelines and justify additional PT. Patient education regarding home exercises and self-management of symptoms should be ongoing components of treatment starting with the first visit. Intervention should include an HEP to supplement therapy visits. Furthermore, the modality, code #G0283 electrical stimulation, is not a supported modality for the diagnosis, ICD-9 code 723.4 brachial neuritis or radiculitis, NOS. Therefore, the submitted request is not medically necessary at this time.”*

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

Patient has been receiving treatments for a minimum of 18 months prior to injury. The ODG was utilized, as well as the designated doctor note indicating a soft tissue injury was the extent of injury with a zero percent impairment rating prior to the time of the IRO. Therefore, the soft tissue injury was resolved as of the time of this IRO and a home exercise program should have been initiated well before this time. There is no support for the use of the electrical modalities requested for this time period related to a soft tissue injury.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES