

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** February 3, 2011

**IRO CASE #:**

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

Eight sessions of cervical physical therapy

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

Board Certified Neurologist

Fellow American Academy of Disability Evaluation Physicians

**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**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a who sustained a work related injury on xx/xx/xx. She was in a and was struck by a defective sliding closet door that came off the hinges as she was opening it. The direct injury was to the region of her forehead and the bridge of her nose.

On July 6, 2010, the patient was seen in follow-up at Health Services for ringing in right ear and posterior headaches. It was noted that the patient had seen neurologist Dr. who had ordered a magnetic resonance imaging (MRI)/magnetic resonance angiogram (MRA) and the results were pending. The patient had been started on tizanidine and an ears, nose, and throat (ENT) evaluation was pending. The diagnoses were tinnitus and persistent headaches. Dr. requested the results of the MRI/MRA and scheduled her to see the ENT.

On July 19, 2010, M.D., a neurosurgeon, performed a peer review and noted the following treatment history:

*The patient was initially seen in an emergency room (ER) and determined to have no evidence of skull fractures in the presence of a normal computerized tomography (CT)*

scan of the head. There is no notation in terms of her ever having had cervical spine radiographs. She was subsequently referred to Dr. with the Occupational Health Services. She was seen by him on the 14th of October and was given clearance in terms of returning to work. The clinical diagnosis was that of a post-concussive syndrome. The neurologic examination was thought to be nonfocal at that time. Earlier on after the patient's injury, she had headache that was primarily posterior or in the region of the occiput and suboccipital. This raises the issue also as to whether or not some of the headache could have been related to the cervical spine leading to cervicogenic headache. There was some component of nausea that required treatment with Phenergan. She was given a combination of Darvocet and Robaxin in the ER but subsequently was prescribed Phenergan by Dr. as well as Ultram for pain. These symptoms persisted over the first two to three weeks post injury, and then a relatively short timeframe later, she described symptoms that seem very much like tinnitus. The patient described it as a "buzzing in her head," The clinical assessment by Dr. as well as Dr. again suggested the diagnosis of tinnitus. Based on this information and Dr. evaluation of June 3, 2010, the clinical impression was that of a posttraumatic concussive syndrome in association with headache and tinnitus. Again, at that time the neurologic examination was nonfocal. It was recommended that the patient undergo MRI scanning of the brain as well as an MRA in order to assess the cerebral vasculature. An ENT evaluation was recommended in addition to prescribing Zanaflex for muscular spasm potentially generated from the head and sub-occiput. The patient's MRI of the brain was essentially normal, while the MRA demonstrated evidence of a hypoplastic right vertebral artery segment with focal area stenoses in distal segments. This latter finding most likely was pre-existing in nature. With the documentation provided, it did not appear as though the patient had seen an ENT specialist as of yet as related to the symptom of tinnitus.

Dr. provided the following opinions: (1) This work related injury represented a physical factor that continued to contribute to the patient's current symptomatology. It did not appear as though this condition was pre-existing. The current complaints seemed directly related to the work-related injury on. (2) The current diagnosis was post-concussive syndrome with associated headache and tinnitus. (3) The effects of the injury had not resolved with residual headache as well as tinnitus. It was unclear as to the duration that these symptoms would persist and it was not unusual to have these symptoms six to 12 months post injury. The patient warranted an ENT evaluation in regards to the tinnitus and the possible requirement for further testing in the form of vestibular studies. (4) The patient should be treated symptomatically as related to the headaches through the neurologist at this stage. As part of the evaluation of possible cervicogenic headache, it would be reasonable to perform an MRI scan of the cervical spine as well as plain x-rays including lateral flexion-extension views. The former study will provide an outline as to detailed anatomy as well as any pathology while the latter could make a dynamic assessment of any instability of the cervical spine that may be a contributing factor to the current symptoms. The only medication that was currently listed was Zanaflex, which was appropriate at this stage. It was not entirely clear as to the duration of its need. (5) The current complaints temporally related to the work-related injury.

On September 9, 2010, the patient presented to M.D., for posttraumatic concussion, vertigo and headaches. She had responded well to Zanaflex but could only tolerate the medication at night secondary to sedation. The vertigo had improved but the headaches returned. She had improved cognitively but continued to have pain in the cervical paraspinous region. Dr. diagnosed posttraumatic headaches related to cervical spasms, improved posttraumatic

vertigo, and posttraumatic concussion with no sequelae. She recommended resuming Zanaflex at night and initiating PT twice a week for eight weeks.

From October 5, 2010, through November 4, 2010, the patient attended six sessions of therapy at Physical Therapy. Modalities consisted of therapeutic exercises, manual traction to the cervical spine and moist hot packs. The plan was to provide additional rehabilitative therapy for two visits a week with an expected duration of four weeks with progression of strengthening/stabilization exercises of cervical spine and upper extremities, neuromuscular re-education, aerobic conditioning, flexibility and functional activities, manual therapy and modalities as needed.

On November 22, 2010, the request for additional eight sessions of PT was denied with the following rationale: *“The claimant is over one year post date of injury and recently completed six sessions. The request for eight additional sessions of physical therapy is not justified based on the clinical records submitted with this request. The claimant should be independent with a home program at this time. There are no updated clinical records from Dr. Monday that would outline therapeutic benefit from the initial PT. Physician Advisor attempted a peer to peer phone discussion with Dr. on 11/22/2010. Spoke with and left a message with call back number. Did not receive a return call.”*

On December 13, 2010, the appeal for additional eight sessions of PT was denied with the following rationale: *“This is who reported an industrial injury to the head and neck on xx/xx/xx, when struck by a closet door. The claimant has completed six PT visits. The claimant had MRI to the neck that is not in the available medical records. On physical exam on September 9, 2010, the claimant had pain in the cervical paraspinous regions. Strength to the upper extremities was normal. Rapid alternating movements were normal in both hands and both feet. The claimant has minimal findings on physical exam and should be able to complete a home exercise program (HEP). The Physician Advisor attempted a peer to peer phone discussion with Dr. x4: 12/08/10 left a message with on voice mail ( ) - with call back number and due date. On 12/09/10, spoke with x2 left call back number. On 12/13/10 spoke with and left a call back number and due date.”*

In a prospective review response dated January 21, 2011, M.D., denied the request and provided the following explanation: *“According to the Spine and Upper Extremities Treatment Guidelines, treatment of a work-related injury must be adequately documented and evaluated for effectiveness. The claimant has had a course of physical therapy in line with Official Disability Guidelines (ODG). As noted above, on 11/02/10, significant improvement was reported. As indicated by the Physician Advisor, additional eight sessions of PT is not justified based on the clinical records submitted. The provider failed to provide any medical evidence that would outline subjective or objective findings to support additional supervised sessions of PT under the CPT codes of 97110, 97140, 97140, 97150 and 97530 as suggested by the provider. Furthermore, the injured worker should have been transitioned into an HEP. Documentation regarding ongoing progress in the recovery process by appropriate re-evaluations, objectively measured and demonstrated functional gains, reduction in pain, and increasing the patient's tolerance to daily activities while continuing with her HEP and work was not submitted. Therefore, based on the reviewed documentation,*

*the medical necessity for eight sessions of cervical PT at Select Physical Therapy as requested by Dr. in a patient who already had six therapy sessions with good response and a level of pain of 0/10 and who should be ready for a HEP is not substantiated at this time."*

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

CLAIMANT SUSTAINED A HEAD INJURY XX/XX/XX. NECK PAIN AND HEADACHES WERE THE MAIN COMPLAINTS. NO NECK X-RAYS WERE EVER DONE SINCE THE INJURY. CLAIMANT HAD MANY TESTS ORDERED AND DONE WHICH APPEARED VERY REASONABLE. SHE WAS SEEN BY DR IN JULY/10 AND NOV/10 AND FELT TO HAVE HEADACHES SECONDARY TO NECK PAIN AND SPASM SECONDARY TO THE INITIAL HEAD INJURY CAUSING A WHIPLASH EFFECT TO THE NECK. INITIALLY MUSCLE SPASM MEDS WERE GIVEN BUT IN LATER VISIT 6 TREATMENTS OF ACTIVE AND PASSIVE PHYSICAL THERAPY WAS APPROVED. ACCORDING TO THE PT NOTES THERE WAS SOME IMPROVEMENT IN THE NECK PAIN. DR ORDERED ANOTHER 8 TREATMENTS OF PHYSICAL THERAPY BUT WAS DENIED BECAUSE OF LACK OF MEDICAL RECORD DOCUMENTATION EITHER VERBALLY OR BY NEUROEVALUATION. ALSO DR. DID NOT RETURN THE PEER REVIEWERS CALL TO DISCUSS THE CASE. I BELIEVE BASED ON ODG GUIDELINES, THE PHYSICAL THERAPY WAS APPROPRIATE TREATMENT FOR THE NECK PAIN. ALSO FLEXION AND EXTENSION XRAYS SHOULD HAVE ALSO BEEN DONE. DR SHOULD HAVE DOCUMENTED HOW THE PATIENT WAS PROGRESSING WITH THE INITIAL 6 PT TREATMENTS AND RETURNED THE REVIEWERS CALL TO SUBSTANTIATE FUTURE 8 MORE PT TREATMENTS. I BELIEVE, IF THE PATIENT IS IMPROVING, IT SEEMS REASONABLE TO CONSIDER MORE TREATMENT. HOWEVER DOCUMENTATION OF IMPROVEMENT IN FOLLOWUP NOTES AND RETURNING REVIEWER PHONE CALLS IS ESSENTIAL. BECAUSE OF THIS FAILURE BY DR. I AGREE WITH THE PREVIOUS REVIEWER THAT 8 MORE TREATMENTS OF PT SHOULD BE DENIED AT THIS TIME. MY OPINION IS BASED ON ODG GUIDELINES AND PROPER PROTOCOL AND PHYSICIAN DOCUMENTATION

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**