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Notice of Independent Review Decision

DATE OF REVIEW: JULY 27, 2011. AMENDED 7/27/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
9 additional visits of therapy for cervical spine

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)

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 (07/11/11 – 07/14/11)

Claims Management Services:

- Office notes (07/06/11 – 07/08/11)
- Diagnostic test (07/06/11)
- Utilization reviews (07/11/11 – 07/14/11)

M.D.:

- Office notes (06/08/11 – 07/13/11)
- Diagnostic test (07/06/11)
- Utilization review (07/11/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was injured on xx/xx/xx. She was hit on the right side of the head with a hoist that caused her neck to bend to the left. She was not rendered unconscious but was dazed by the blow.

On June 8, 2011, D.C., evaluated the patient for complaints of headache and pain in the neck spreading down to her upper trapezius muscle. Examination revealed a painful lump on the right temporal area of the cranium, reduced movement of the cervical spine in all planes with discomfort at spinal levels C1-C7 and at the base of the occiput. She had a positive Spurling's test and hypertonicity of the cervical paraspinal musculature on digital palpation. Dr. diagnosed closed head injury without loss of consciousness and cervical radiculitis, secondary to grade II strain (rule out further pathology). He referred the patient for further diagnostics of the head and neck and recommended therapy program on approval.

In July, Dr. noted aggravation of the head and neck with physical activities. The patient had attended therapy and reported an increase in her flexibility of the cervical spine. Examination revealed positive Soto-Hall and compression test in addition to the previous examination findings. Dr. continued medications and opined that the patient would benefit from therapy.

Per pre-authorization request, 9 sessions of physical therapy (PT) were requested with modalities consisting of therapeutic exercises/activities and neuromuscular re-education.

A magnetic resonance imaging (MRI) of the cervical spine revealed: (1) Mild scoliotic curvature of the cervical thoracic spine, mild straightening of the mid upper cervical distribution. An element of mild congenital narrowing AP dimension mid to lower cervical spine was present on the basis of short pedicles. (2) At C2-C3 and C3-C4, there was minimal spondylosis. (3) At C4-C5, there was a broad-based mixed protrusion slightly less than 3 mm, more prominent left paracentral distribution with slight effacement of the thecal sac. (4) At C5-C6, there was mild spondylosis, broad-based mixed protrusion of about 3.5 mm, with a prominent left paracentral component abutting and slightly effacing the cord. There was mild central stenosis, mild bilateral foraminal narrowing, mild facet arthropathy bilaterally and uncovertebral joint hypertrophy. (5) At C6-C7, there was broad-based protrusion, nearly abutting the cord. There was mild central stenosis, mild foraminal narrowing leftward and mild bilateral facet arthropathy. (6) At T1-T2, there was small central protrusion, slightly greater than 3 mm and borderline central canal narrowing. (7) At T2-T3, there was central protrusion about 4 mm abutting and slightly effacing ventral aspect of the cord.

On July 8, 2011, M.D., denied the request for 9 additional visits of therapy for cervical spine based on the following rationale: *"The patient is a lady who has a diagnosis of cervical sprain/strain and she has received 10 visits of physical therapy with some improvement in range of motion. However, it is not specified in the records provided if this improvement and range of motion is translated to increased functional improvement including increased level of activity and work, as well as increase in restrictions at work and improvement in her ability to*

perform her activities of daily living as well as her work duties. An MRI of the head and neck that was requested earlier by the treating physician is pending. According to the ODG Guidelines, 10 visits of physical therapy are deemed appropriate for this diagnosis and if guidelines are exceeded, an exceptional factor should be noted, according to the guidelines. In this patient, there are no obvious exceptional factors that are specified in the records provided. A valid rationale identifying why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. There is no evidence of any objective activity limitation that is specified in the records provided. Also, the response of the patient's pain to analgesics is not specified in the records provided. With this, it is deemed that the medical necessity of 9 additional visits of physical therapy is not fully established in this patient at this time given the clinical information submitted and the peer-reviewed guidelines referenced'. He recommended transitioning the patient to an independent home exercise program (HEP).

M.D., noted worsened pain in the neck and tingling in the left arm. The patient also reported trouble sleeping and aching and burning pain in the neck and shoulders. Examination revealed diminished left biceps jerk, sensory loss in a left C6-C7 pattern and weakness in the triceps. Dr. recommended an electromyography/nerve conduction velocity (EMG/NCV) study of the upper extremities prior to making any surgical decision.

In an appeal, 9 sessions of PT was requested with modalities consisting of therapeutic exercises/activities and neuromuscular reeducation.

On July 13, 2011, a peer-to-peer phone conference was held with Dr.. Dr. noted the reviewer did not say if he would approve the care that was requested. The reviewer did not attempt to negotiate the patient's care.

On July, 14, 2011, M.D., denied the appeal for 9 additional visits of therapy for cervical spine based on the following rationale: *"The request for 9 additional visits of therapy for the cervical spine is non-certified. The documentation submitted for review elaborates the patient with subjective complaints of ongoing head and neck pain. Official Disability Guidelines (ODG) recommend 10 physical therapy sessions for an injury of this nature. The documentation details that the patient had previously completed 10 physical therapy sessions to date. This request exceeds guidelines recommendations and no exceptional factors were noted in the documentation. Physical examination findings do not support the medical necessity of additional supervised therapy. It would be reasonable to expect that the patient would be able to continue in a home exercise program. Given the excessive nature, this request does not meet guideline recommendations. Therefore, the request for 9 additional physical therapy visits for the cervical spine is not medically necessary and is non-certified"*.

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

THERE IS INSUFFICIENT MEDICAL EVIDENCE TO SUPPORT THE NECESSITY OF ADDITIONAL THERAPY WHICH DOUBLES THE AMOUNT OF SESSIONS RECOMMENDED BY ODG. IT IS REASONABLE THE EXAMINEE CONTINUE IN A HOME BASED PROGRAM, AND FORMAL THERAPY SHOULD NOT BE NECESSARY CERTAINLY NOT NINE ADDITIONAL SESSIONS.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**