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Notice of Independent Review Decision

DATE OF REVIEW: December 19, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Therapy 97140, 97035 and 97110 x12 visits.

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

Chiropractor

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

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- Office visits (06/24/11 – 10/31/11)
- Diagnostics (11/18/08 – 10/13/10)
- Surgery (02/17/11)
- Utilization review (11/04/11 – 11/22/11)

Dr.:

- Office visits (10/16/08 – 10/31/11)
- Diagnostics (11/18/08 – 10/13/10)
- Surgery (01/22/09 – 02/17/11)

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- Utilization review (11/04/11 – 11/22/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was in the process of doing a tie down near the vehicles on the lower level of the trailer. He was holding on to a chair with his

right hand when he slipped and fell hitting his back and sustained injuries to his left elbow, right shoulder, neck, mid and low back as a part of the accident on xx/xx/xx.

2008: From October 16, 2008, through December 9, 2008, the patient was evaluated by D.C., M.D., an orthopedic surgeon and D.O., for injury to the left elbow, right shoulder, neck, mid and low back. He was initially evaluated at Clinic and was treated with ibuprofen, cyclobenzaprine and physical therapy (PT). Examination revealed depressed affect, decrease perception of vibration in the right hand and arm and right leg, decreased pinwheel perception, decreased range of motion (ROM), weakness in both shoulders on resistance testing, painful lumbar rotatory extension procedures and spasm in the cervical, thoracic and lumbar paraspinal muscles. Cross arm, Hawkins tests were positive and there was some crepitation over the anterior cuff with internal and external rotation and tenderness over the anterior cuff and subacromial space.

Magnetic resonance imaging (MRI) of the lumbar spine revealed multilevel annular disc bulges, left lateral disc bulges at L1-L2 and L2-L3 affecting the extraforaminal L1 and L2 nerve roots, right lateral disc bulge at L3-L4 affecting the extraforaminal right L3 nerve root, posterior displacement of left S1 nerve root at L5-S1 in the lateral recess due to left-sided broad-based disc herniation or annular disc bulge and deformity of the thecal sac at L5-S1 possibly representing arachnoiditis. MRI of the right shoulder revealed high grade partial thickening tear of the anterior and supraspinatus tendon, infraspinatus tearing, intrasubstance tearing of the subscapularis tendon with slight medial subluxation of the long head of the biceps tendon, mild inferior surface tearing of the superior labrum and moderate AC joint osteoarthritis with synovitis in the AC joint. X-rays of the left elbow revealed questionable small elbow joint effusion. Flexion/extension views of the lumbar spine revealed segmental instability at L1 to L2-L3 and L4-L5 and mild vertical disc space narrowing of L3-L4 and L4-L5. X-rays of the right shoulder revealed mild AC joint space narrowing. MRI of the right elbow revealed moderately severe lateral epicondylitis with intrasubstance tearing of the common tendon origin and thickening of the adjacent radial collateral ligament, mild chondromalacia in the medial ulnohumeral joint. MRI of the left elbow showed moderately severe lateral epicondylitis with intrasubstance tearing of the common extensor tendon origin and thickening of the adjacent radial collateral ligament and mild chondromalacia in the medial ulnohumeral joint. The patient was treated with Lidocaine and was recommended injections to the shoulder, medial branch blocks and therapy.

2009: From January through December, the patient was evaluated by Dr. Dr. and Dr. for rotator cuff tear with impingement, possible labrum tear and bicep subluxation, facet syndrome, facet joint syndrome, low back pain, left elbow pain, left shoulder pain and discomfort in the right shoulder. The patient underwent electromyography/nerve conduction velocity (EMG/NCV) study of the upper and lower extremities that revealed possible left and right shoulder internal injury and mild slowing of the sensory latencies of the ulnar nerve. Lower extremity sampling demonstrated acute radiculopathy in the bilateral L4, L5 and S1 motor roots. MRI of the left shoulder revealed impingement syndrome with mild subdeltoid bursitis and 1-cm high grade partial thickness tear of the supraspinatus tendon involving greater than 75% of the tendon thickness and mild anterior surface fraying at the superior and anterior segments of the labrum.

The patient was treated with right shoulder arthroscopy, arthrotomy, Mumford acromioplasty, bursectomy and repair of the rotator cuff, lateral epicondylectomy and repair of the common extensor and left shoulder modified Mumford acromioplasty and rotator cuff repair. He attended therapy and was started on Ultracet.

2010: From January through November, the patient was evaluated by Dr., Dr. M.D., a pain management physician, Dr., Dr. M.D., M.D., an orthopedic surgeon, for low back pain and leg pain primarily on the left side. He was progressing satisfactorily in regards to his shoulder. Examination of the lumbar spine revealed pain on flexion, hyperextension and rotation, bilateral paraspinous muscle spasm left greater than right, positive SLR on the left at 50 degrees with numbness and tingling into the left calf, positive spring test at the intra iliac crest line, positive extensor lag and sciatic notch tenderness, positive flip test on the left and Lasegue's and Bragard's and decreased ankle jerk on the left. The paresthesia was noted in the L5 and S1 nerve root distribution on the left with weakness of gastrosoleus. The patient was diagnosed with L5-S1 herniated nucleus pulposus (HNP) with posterior annular tear and abutment of the left S1 nerve root, radiculopathy at left L4, L5 and S1 and persistent low back pain with radicular signs and symptoms since the date of accident resistant to conservative treatment. The patient was treated with epidural steroid injection (ESI) at L5 and S1 x2 followed by therapy. Dr. had recommended surgical intervention.

In October, MRI of the lumbar spine showed right-sided disc herniation at L5-S1 with compression of the right L5 and S1 nerve roots with mild impression on the left L5 nerve root in the neural foramen, right posterior lateral disc bulge at L3-L4 with impression on the extraforaminal right L3 nerve root and mild impression on the right L3 nerve root in the neural foramen, a small broad-based disc bulge with annular tearing at L4-L5 and mild compression of both L4 nerve roots in the neural foramen and synovitis and/or effusion in the L3-L4, L4-L5 and L5-S1 facet joints with reactive marrow edema in the L5 pars. In November, Dr. evaluated the patient for back pain and bilateral leg pain worse on the left than the right. He reviewed MRI and recommended surgical intervention.

2011: On February, 17, 2011, Dr. performed examination under anesthesia (EUA) and pain study, lumbar laminectomy, discectomy, decompression and neural foraminotomy at bilateral L5-S1, additional interspace decompression with exploration of the disc facet L4-L5 bilaterally, decompressive laminectomy of the sacrum bilaterally with decompression of cauda equina and neural foraminotomy of both S1 nerve roots and microdissection technique harvesting and preparation of bone graft. Postoperatively, the patient attended therapy consisting of exercises and STM.

On June 24, 2011, Dr. noted the patient had made some progress and had gained some strength in his legs. Dr. noted that the patient was seen by Dr. for a post-designated doctor evaluation. He disagreed with Dr. opinion as he seemed to attribute most of the patient's injuries to ordinary disease of life in pre-existing condition which was not appropriate. He recommended continuing therapy and referred the patient to an orthopedic surgeon for consideration of MUA.

In August, Dr. evaluated the patient for back stiffness and radiation of pain into the leg. Examination showed well-healed midline incision without paravertebral

muscle spasm, extensor lag, sciatic notch tenderness and negative tests. Dr. recommended consultation with chronic pain management physician for evaluation of medication and functional capacity evaluation (FCE) and EMG/NCV of both lower extremities. Dr. noted that the patient was slowly getting stronger and recommended more therapy and rehab for low back. In October, the patient reported low back pain on constant basis, difficulty sleeping because of back pain and very difficult time getting back-up from floor and had to crawl for a little bit and sort of work his way of furniture. Dr. suspected adhesive capsulitis and ordered MR arthrogram to delineate the extent of the adhesive capsulitis. He recommended referral to an orthopedic surgeon for evaluation. A request for physical therapy (PT) was made on October 31, 2011.

Per utilization review dated November 4, 2011, the request for 12 sessions of PT for lumbar spine was denied by D.C., with the following rationale: *“Unfortunately, I was unable to determine the medical necessity of this request. It is not entirely clear how many post-op therapy sessions claimant has had, given that surgery is now over eight months old especially with regard to ODG suggested timeframe of 16 weeks. Likewise, the use of ultrasound over the installed cages may be problematic and number of times unit per visit (6) exceeds ODG recommendations. Finally, I could not find the September 28, 2011, report referenced on fax cover sheet and therefore, most recent to refer to was dated August 28, 2011, which is now over two months distant and has somewhat scant lumbar exam findings but notes flexion a very good 85 degrees. Pending clarification, request is recommended for non-certification at this time.”*

Per reconsideration review dated November 22, 2011, the appeal for 12 sessions of PT for lumbar spine was denied with the following rationale: *“The request for 12 additional physical therapy visits over 4 weeks is not medically necessary. The claimant’s trauma was 3 years ago and he has completed all levels of conservative treatment as well as surgical intervention for lumbar disc pathology. He is well established in the chronic phase of his recovery where the continued administration of provider driven care is not supported as medically necessary. There is no indication that the claimant suffered a re-exacerbation of his condition and there is no support from ODG guidelines for additional care to be appropriate for his chronic condition. As such, the request for an additional 12 treatments is not recommended for certification.”*

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

Review of the records provided reveal 24 post-surgical physical therapy and rehabilitation exercises from 5-16-11 through 8-15-11 with good results. Subjective pain levels went from 5/10 to 3/10. Subjective comments on the last day report “patient says the LB feels better than usual today.” This does follow the ODG guidelines which allows for 16 visits over 8 weeks. Additional physical therapy is not medically necessary or advised under the ODG Guidelines.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES