

Notice of Independent Review Decision

**DATE OF REVIEW:** June 6, 2012

**IRO CASE #:**

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

Post-injection physical therapy x3 sessions

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

Fellow of the 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**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who on xx/xx/xx , was xxxxx started to experience immediate neck, right shoulder and low back pain.

**2011:** On xx/xx/xx, the patient was seen by MD., at xx for pain in the neck and back associated with stiffness. Examination of the cervical spine showed tenderness in the right paraspinous area. Examination of the lumbar spine showed decreased flexion with pain at L3, L4 and L5 spinous processes and paraspinous areas bilaterally. Dr. diagnosed cervical and lumbar strain, prescribed Skelaxin, recommended use of ice/cold pack and Bio-freeze and scheduled the patient for therapy.

D.C., evaluated the patient for numbness and tingling sensation from the knees down to her feet in both legs, pain radiating down from her neck and into the shoulders and arm, moderate neck pain, difficulty rotating her head and moderate right shoulder pain radiating down the right arm. Examination of the spine showed pain in the neck radiating down into the right shoulder and arm; positive cervical distraction; positive drop arm test, positive Apley's scratch test; positive apprehension test on the right; positive supraspinatus press test on the right; provocative straight leg raise (SLR) for lumbosacral pain and radicular symptoms bilaterally; positive Kemp's test; positive Patrick's test bilaterally; positive Ely's test bilaterally; positive Nachlas test bilaterally and provocative Yeoman's test for lumbosacral pain as opposed to sacroiliac (SI) pain. Strength was reduced in the right deltoid, supraspinatus and biceps and triceps musculature. There was moderate tenderness in the supraspinatus, infraspinatus and deltoid regions, specifically on the anterior aspect in the right shoulder. There was corresponding hypertonicity of the right trapezius and the cervical paraspinal musculature, moderate tenderness along the suboccipital region with corresponding tenderness along the cervical paraspinal muscles and moderate tenderness along the lumbar paraspinal musculature, greater along the left side. Dr. diagnosed cervical radiculitis, cervical sprain/strain, right shoulder sprain/strain and lumbar radiculitis and requested pre-authorization for physical rehabilitation for the cervical, lumbar and right shoulder.

From xx/xx/xx, through August 19, 2011, Ms. attended 12 sessions of physical therapy (PT) consisting of electrical muscle stimulation (EMS), ultrasound, myofascial release, hot packs and manual therapy.

Computerized muscle testing and ROM testing dated August 16, 2011, showed restricted range of motion (ROM) in the cervical and lumbar spine, restricted ROM in the right shoulder and strength deficits in the left hip, left knee, left ankle, right shoulder, right elbow and right wrist when compared bilaterally.

Dr. noted the patient continued to have moderate burning painful sensations radiating from the neck down into the right shoulder and upper extremity and the same burning painful sensation in the low back and decreased numbness and tingling sensations in the legs with active exercises. He recommended magnetic resonance imaging (MRI) of the cervical spine and physical performance evaluation (PPE) and issued a transcutaneous electrical nerve stimulation (TENS) unit and Biofreeze.

A PPE dated August 19, 2011, demonstrated that the patient was able to safely and dependably perform at a sedentary physical demand level (PDL), which failed to meet the minimum job requirement.

On November 5, 2011, MRI of the cervical spine showed straightening of the cervical lordosis in keeping with muscle spasm, 1-mm central disc bulge at C4-C5 and minimal central posterior bulge at C5-C6. MRI of the lumbar spine showed straightening of the lumbar lordosis suggestive of spasm, disc space narrowing with 2.5-mm disc protrusion at T10-T11, mild hypertrophy of the facets and ligamentum flavum causing mild spinal stenosis with slight foraminal encroachment at L4-L5 and right renal cyst.

M.D., reviewed the MRI findings and diagnosed cervical myofascial pain and low back pain of probable facet etiology. He recommended trying a short course of oral analgesics or anti-inflammatories and continued PT and if not, the patient might be a candidate for possible trigger points for cervical and/or possible facet injection for lumbar spine.

**2012:** In January, the patient reported she did very well with Medrol Dosepak, Celebrex and tramadol with a combination of PT. Her neck pain had resolved and she was back at work but her back pain had not subsided. Examination of the back revealed significant paraspinous tenderness, pain in the L4-L5 distribution left greater than right, and positive Kemp's test on the left greater than right. The patient was assessed with cervical and lumbar sprain/strain.

A PPE performed on January 5, 2012, demonstrated the patient's ability to safely and dependably perform at a sedentary light PDL, which failed to meet the minimum job requirement.

, MA, LPC-S, performed a psychological evaluation and noted the patient was having difficulty managing her pain and experienced a great deal of interference with activities of daily living (ADL) due to her pain and difficulties adjusting to her injury. The patient reported feelings of depression, anxiety, irritability, restlessness and some sleep problems despite multiple levels of intervention with a high level of stress regarding the treatment process of her injury and would prefer to return to work without experiencing pain and other physical symptoms. The patient scored 13 on the Beck Depression Inventory II (BDI-II) which was within the mild-to-moderate range of the assessment. She scored 13 on the Beck Anxiety Inventory (BAI) which was within the low/mild range of the assessment. felt that there was a strong indication that the patient was experiencing pain that was creating interference in her life. She diagnosed acute pain disorder with both psychological factors and a general medical condition and recommended participating in a work hardening program (WHP) followed by re-evaluation for chronic pain, depression, anxiety and psychological functioning to determine the patient's potential need for a chronic pain management program (CPMP).

In February, Dr. opined that the patient was having exacerbation of ongoing low back pain that on physical examination and imaging studies appeared to be facet related. He recommended diagnostic medial branch block targeting the L4-L5, L5-S1 and medial branches bilaterally to address the L4-L5 facet joint. If indeed she benefitted then possible radiofrequency thermocoagulation (RFTC) could be considered.

Per an IRO dated March 9, 2012, the adverse determination for initial WHP for ten sessions was upheld.

On March 30, 2012, Dr. performed L4, L5 and S1 diagnostic medial branch blocks bilaterally.

On April 5, 2012, the patient reported she was doing significantly better and noted 90% reduction in her pain immediately post-injection with the pain diminishing from 10/10 down to a 1/10 bilaterally. Dr. opined that he would not recommend the radiofrequency as the patient was doing well and having relief.

He recommended using nonsteroidal antiinflammatory for one month. If the pain would not last then the patient would be a reasonable candidate for considering the RFTC.

Dr. noted the patient experienced improvement in low back pain and a decrease in burning sensation across her low back. She continued to experience moderate soreness at the injection site as well as slight burning sensation across the low back, but she could definitely notice a relief in pain. She noticed improved bending and stooping tolerance at work. She continued to utilize her transcutaneous electrical nerve stimulation (TENS) unit for additional pain control. Dr. recommended submitting pre-authorization for three sessions of post-injection physical rehabilitation for the lumbar spine; review on proper lifting techniques, biomechanics and posture in order to ensure proficiency with the current exercises as well as prevent further aggravation of her low back at work. He also recommended retaining the patient with additional core stabilization and lumbar strengthening exercises to further supplement her current home exercise region. He continued TENS unit for additional pain control and follow-up with Dr. as scheduled.

Per utilization review dated April 10, 2012, the request for post-injection physical therapy lumbar spine x3 sessions and manual therapy lumbar spine x3 sessions was denied based on the following rationale: *“ESIs are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation. Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research that addresses the use of physical therapy post ESIs, but it appears that most randomized controlled trials have utilized an ongoing, home-directed program post injection. Based on current literature, the only need for further physical therapy treatment post ESI would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than 2 additional visits to reinforce the home exercise program. ESIs have been found to have limited effectiveness for treatment of chronic pain. The claimant should continue to follow a home exercise program post injection. (Luijsterburg, 2007) (Luijsterburg2, 2007) (Price, 2005) (Vad, 2002) (Smeal, 2004).”*

Per the reconsideration review dated April 18, 2012, the appeal for post-injection physical therapy lumbar spine x3 sessions and manual therapy lumbar spine x3 sessions was denied based on the following rationale: *“Issues brought up on initial level review were not addressed. There is no medical explanation as to what the role of the additional three sessions of supervised rehab would be and how it would reasonably be any more effective than continuation of the independent HEP that the patient was taught by this provider earlier. There is no medical necessity for an additional three sessions of supervised rehab just because the patient had some diagnostic medial branch blocks on 3/30/12. Case was discussed. Dr. confirmed that the patient has an established independent home exercise program. Recommendation remains adverse.”*

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

Based on the literature and ODG one to two sessions of post injection therapy is reasonable, but three is not recommended. Therefore, the decision was upheld.

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**