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Notice of Independent Review Decision

October 27, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 12 sessions comprising 97110, 97140, 97112, 97010, and 97032

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

Board Certified Physical Medicine and Rehabilitation Physician

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.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI

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M.D.

LHL602.

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx was walking down a wet ramp at his job and fell and sustained injuries to his neck and right shoulder.

2007: No records are available.

2008: On xxxx, magnetic resonance imaging (MRI) of the lumbar spine showed the following findings: (1) At L1-L2, minimally degenerated disc and anterior osteophyte. (2) At L4-L5, moderate-to-severe effacement of the thecal sac owing to a 4-mm broad-based central disc herniation, moderate-to-severe hypertrophy of the facets and ligamentum flavum and congenital spinal stenosis and 2 mm of 3 mm of anterolisthesis of L4 and mildly degenerated disc. (3) At L5-S1, a 1-mm disc bulge, mild hypertrophy of the facets, minimally degenerated disc and subcentimeter synovial cysts adjacent to the LS spinous process bilaterally. There was mild-to-moderate congenital spinal stenosis at this level.

On February 7, 2008, MRI of the right shoulder revealed high-grade supraspinatus and subscapularis tendinosis with a high-grade partial-thickness anterior margin insertional tear of the supraspinatus tendon extending into the anterior interval and an 8-mm subcortical cyst immediately deep to the anterior supraspinatus insertion within the greater tuberosity, probably associated with a longstanding partial insertional tear, high-grade bicipital tendinosis and acromioclavicular (AC) joint arthritis noted as well as downturned acromion with bony subacromial spur.

On July 21, 2008, M.D., evaluated the patient for cervical and right shoulder complaints. He noted that the patient was diagnosed with C1-C2 instability with a small spinal cord syrinx at C1-C2. The patient was pending cervical posterior fixation with neurosurgeon, Dr., and arthroscopic surgery with Dr., an orthopedic surgeon. The patient had two injections, physical therapy (PT), and medication trials. History was positive for hypertension and diabetes, left knee and right knee injury. Examination showed some mild tenderness at the craniocervical junction and in the cervical paraspinal muscles, positive impingement signs at the right shoulder, decreased muscle strength and some give-way with testing of the right shoulder secondary to pain. Dr. assessed C1-C2 ligamentous instability, pending surgical intervention, right shoulder rotator cuff tear status post injections and now pending arthroscopic surgery and low back pain. He recommended continuing off work duty status, home exercise program (HEP) and follow-up after surgery.

On September 23, 2008, x-rays of the cervical spine showed fixation screws extending from the articular masses of C2 into the lateral masses of C1 bilaterally; posterior fusion of the posterior arch of C1 and spinous process of C2 with fixation by a K-wire, bony disc graft within the interspinous space between C1 and C2 not yet solidly incorporated. The os odontoideum anomaly of the dens was noted with a separate C1 vertebral body and a disc space between the dens and the body of C2. The mild, 1-mm retrolisthesis of C5 upon C6 was again noted. Disc space narrowing and marginal osteophyte formation noted at C6-C6 and C6-C7.

In October, Dr. noted the patient had C1-C2 fusion on August 6, 2008. He had some posterior cervical and cranial numbness and some residual pain, but overall was better. He had anxiety and insomnia and low back pain. Examination showed tenderness in the cervical and lumbar paraspinals. He had positive impingement sign in the right shoulder. Dr. assessed C1-C2 ligamentous instability status post surgical intervention on August 6, 2008, right shoulder rotator cuff tear pending arthroscopic surgery, low back pain and insomnia with an anxiety component. The patient was to follow-up with Dr. and Dr., and Dr. for insomnia with nightmares. Dr. recommended continuing home walking and range of motion (ROM) program and off work.

On November 6, 2008, x-rays of the cervical spine showed postoperative changes of posterior fusion of C1 and C2, os odontoideum fusion anomaly; a grade 1, 1-mm retrolisthesis of C5 upon C6, degenerative spondylosis and degenerative disc disease (DDD) at C5-C6 and C6-C7.

Dr. noted the patient had stopped using hydrocodone as recommended by Dr. following which he had better sleep. He was seen by Dr. and Dr. for his cervical and shoulder complaints respectively. However, he had low back pain with some radiation down the right lower extremity. Dr. assessed low back pain with right lower extremity radiculitis with known L4-L5 central disc herniation and severe facet hypertrophy. He recommended PT, cutting down the dose of Tylenol if possible and a series of lumbar epidural steroid injections (ESIs).

2009: In January, Dr. noted the patient had had two lumbar ESIs out of which the first one decreased the right leg pain by 50% and the second one did not change the right leg symptoms. The patient had some transient increased low back pain following the injection. He was in PT which was helping. He had follow-ups with Dr.. Dr. recommended continuing PT and Tylenol.

In February, Dr. noted the patient had completed therapy and was released to HEP. He had ongoing cervical pain and low back pain as well as right shoulder pain. He was utilizing Naprosyn which was helping. His C1-C2 fusion was noted to be healing well. He was off work. He had limited cervical and lumbar spine ROM and right shoulder ROM. Dr. opined that the patient had reached maximum medical improvement (MMI) and recommended continuing HEP and Naprosyn or over-the-counter (OTC) analgesics and proceeding with impairment rating.

In June, Dr. rescinded the previous date of MMI. The patient had some posterior cervical pain radiating up into his head bilaterally. Examination showed limited ROM of the right shoulder with some guarding. He also had limited cervical ROM and minimal tenderness in the cervical paraspinal muscles. Dr. recommended HEP, Naprosyn or OTC analgesics and follow-up with Dr..

On follow-up in August, Dr. noted the patient had right shoulder rotator cuff surgery. He was attending therapy and had follow-ups with Dr.. He was using a sling. He had some mild tenderness in the lumbar and cervical paraspinal muscles. He was progressing well with his rehabilitation for his right arm and was utilizing minimal medications including Tylenol and tramadol occasionally. Dr. opined that the patient was a good candidate for retraining in a sedentary position.

In October, Dr. noted that the patient had ongoing cervical pain and radiating radicular pain into the arms. He recommended MRI of the cervical spine and a repeat electromyography/nerve conduction velocity (EMG/NCV) study of the bilateral upper extremities as recommended by Dr..

On December 10, 2009, MRI of the cervical spine showed the following findings: (1) Os odontoideum anomaly of the dens status post posterior fusion of C1 and C2. (2) Borderline congenital cervical spinal canal stenosis. (3) Small syrinx at the C1 level, unchanged. (4) A 1.1-mm central disc protrusion at C4-C5 leading to mild stenosis of the spinal canal. (5) Disc osteophyte complex at C5-C6 leading to moderate stenosis of the spinal canal. Bilateral uncovertebral hypertrophy leading to mild bilateral neural foraminal stenosis. (6) Mild disc bulge at C6-C7 and C7-T1 leading to mild stenosis of the spinal canal.

In December, Dr. noted that the patient had a designated doctor evaluation (DDE) and was placed at MMI with 26% whole person impairment (WPI) rating. The patient was seen by Dr. who recommended holding any surgery. The patient had bilateral upper extremity pain, numbness and tingling at times. Dr. reviewed the MRI findings and assessed C1-C2 instability status post cervical fusion and underlying C4-C5 disc protrusion and C5-C6 disc osteophyte complex, right shoulder rotator cuff tear and subsequent repair and low back pain with right lower extremity greater than left radiculitis with L4-L5 disc herniation and stenosis. He recommended continuing medications, short course of PT and EMG/NCV.

2010: From March through December, the patient had follow-ups with Dr. every three months for cervical and lumbar complains. He noted that the patient was hospitalized in March for gastrointestinal (GI) bleeding after starting Naprosyn. He was taken off Naprosyn and was utilizing Flector patches and Tylenol. He continued to have tenderness in the cervical and lumbar paraspinal muscles. Dr. opined that the GI bleeding should be considered work-related. He maintained the patient on Lidoderm patch and Tylenol.

In December, Dr. noted that the patient was seen at the emergency room (ER) for back pain. He was maintained on flexor patches for right shoulder by Dr.. He was using a single-point cane to ambulate. He reported that his back pain was at a level where he would consider surgical intervention. Dr. recommended an updated MRI scan of the neck and low back and follow-up with Dr..

On December 22, 2010, MRI of the lumbar spine showed the following findings: (1) At L1-L2, minimal loss of disc height with mild degenerative disc signal. (2) At L2-L3 and L3-L4, preserved disc height with mild degenerative disc signal, mild facet arthropathy. (3) At L3-L4, neural foramina slightly encroached upon. (4) At L4-L5, mild loss of disc height with degenerative disc signal. Severe facet arthropathy resulting in a slight 2-mm anterolisthesis of L4 on L5 resulting in severe spinal canal stenosis and mild-to-moderate bilateral foraminal encroachment. The listhesis had slightly progressed from prior, as was spinal canal stenosis at this level. (5) At L5-S1, preserved disc height with mild degenerative disc signal, slight disc bulging with evidence for tiny posterior annular tear, moderate facet joint degenerative changes on the left and mild degenerative changes on the right. Neural foramina were slightly encroached upon.

2011: In January, Dr. noted ongoing low back pain radiating into the right lower extremity, mainly the upper aspect of the anterolateral thigh, and cervical pain. Dr. reviewed the MRI of the lumbar spine and recommended use of hydrocodone as needed for pain and course of PT.

On February 9, 2011, computerized tomography (CT) scan of the cervical spine showed fusion of the C1 and C2 vertebral segments without evidence for hardware failure or loosening, multilevel degenerative changes and degenerative joint changes, worse at C5-C6 and C6-C7 causing a mild central canal stenosis and neural foraminal narrowing at these levels.

MRI of the cervical spine showed the following findings: (1) At C2-C3, mild bilateral facet arthrosis. (2) At C3-C4, mild bilateral uncovertebral joint hypertrophy. (3) At C4-C5, bilateral facet arthrosis and uncovertebral joint hypertrophy causing moderate stenosis of the left neural foramen. (4) At C5-C6, small circumferential disc bulge with the posterior disc osteophyte complex causing slight mass effect on the ventral spinal cord and effacing the cerebrospinal fluid (CSF) signal around the cord consistent with moderate-to-severe central canal stenosis. This appeared to have progressed compared with the prior study. There was severe right and moderate-to-severe left neural foraminal narrowing at this level. (5) At C6-C7, circumferential disc bulge with bilateral facet arthrosis and uncovertebral joint hypertrophy flattening the ventral spinal cord consistent with moderate central spinal canal stenosis. Moderate bilateral neural foraminal narrowing. (6) At C7-T1, small circumferential disc bulge flattening the anterior thecal sac consistent with mild central canal stenosis. (7) Postsurgical changes noted within the subcutaneous tissues of the posterior neck at C2-C3.

In March, Dr. noted that PT was denied. The patient had ongoing low back pain, cervical pain and right lower extremity predominantly proximal pain, numbness and tingling. He had limited ROM of the lumbar and cervical spine. Dr. recommended continuing hydrocodone, Lidoderm patches, HEP and follow-up with Dr..

In a letter of medical necessity, Dr. opined that the narcotic medications were necessary and helped relieve the pain symptoms.

On follow-ups in June and September, Dr. noted that the patient was doing the same. He continued to have cervical, lumbar and right shoulder pain. The patient was progressively getting worse. Dr. had recommended the need for surgical decompression at the cervical and lumbar spine. Dr. recommended continuing hydrocodone, Lidoderm patches and HEP. It was noted that the patient was going to pursue surgical intervention with Dr. on both his neck and low back.

In October, Dr. opined that the fall had caused an aggravation and essentially permanent change to that point of his underlying degenerative lumbar spine.

2012: On March 27, 2012, Dr. noted the patient continued to have cervical pain and low back pain with some radiation into the arms and legs. Apparently, there was a dispute in regard to the extent of his compensability for his low back pain. The hearing was scheduled in June. The patient was utilizing Lidoderm patches, flexor patch and hydrocodone. He was following up with Dr. and Dr.. He was not able to return to any type of gainful employment and HEP. Dr. recommended continuing the Lidoderm patches and flexor patch and follow-up in six months or sooner.

On July 26, 2012, the patient reported ongoing both cervical and low back pain which had progressed over the last several weeks to months. He had some radiation into the arms and legs which had not changed significantly from the past. He was utilizing Lidoderm patches and occasionally hydrocodone for breakthrough pain. Examination showed tenderness in the cervical paraspinal muscles as well as in the upper trapezius and levator scapulae muscles. He had fair cervical ROM limited in all planes. He had tenderness in the lumbar paraspinal muscles bilaterally and gluteal muscles. Straight leg raising in the seated position produced back pain and some radiation down the respective posterior thighs. Dr. assessed C1-C2 instability status post cervical fusion; C5-C6 and C6-C7 stenosis, right shoulder rotator cuff tear status post surgical repair and low back pain with bilateral lower extremity radiculitis with L4-L5 disc herniation and stenosis. Dr. recommended a short course of PT for his neck and back pains especially his low back which was not really addressed as much as the neck pain in the past. The patient was to continue medication regimen and follow-up in six months or sooner.

On August 16, 2012, the patient underwent PT evaluation at Integrity Rehab. The treatment plan was 12 sessions of PT consisting of repetitive movements into cervical and lumbar extension, correct sitting position instructions, local modalities for pain relief, manual therapy as indicated and progress to functional strengthening exercise as tolerated.

On August 23, 2012, a pre-authorization review request form was submitted for PT.

Per utilization review dated August 29, 2012, the request for PT was denied with the following rationale: *“Guidelines recommend a total of ten sessions of physical therapy over eight weeks for the medical treatment of an intervertebral disc disorder without myelopathy and nine visits of physical therapy over eight weeks for neck pain and cervical spondylosis. The claimant sustained an injury in xxxx with no recent re-injury documented and no significant changes in physical examination or subjective complaints based on the documentation provided that would indicate a need to proceed with acute physical therapy at this time. The request for twelve physical therapy sessions is not certified.”*

On September 5, 2012, Dr. xxxxx submitted a letter of medical necessity stating that the requested treatment was medically necessary and appropriate and related to the patient’s previous work-related injuries.

On September 12, 2012, Dr. prescribed three sessions of PT per week for four weeks. The diagnosis was low back pain with left lower extremity radiculopathy with L4-L5 disc herniation and cervical pain status post C1-C2 fusion.

Per reconsideration review dated September 27, 2012, the request for 12 sessions of PT was denied with the following rationale: *“Records reveal a date of injury 5 years out. The PT referral script indicates PT will address 1) LBP w/ radiation w/ disc herniation 2) Cervical pain s/p fusion. The date of lumbar MRI was December 22, 2010, which revealed spondylosis. I spoke with the requesting provider. He stated the patient has not had formal therapy for the lumbar spine, request was not for cervical spine. A therapy note dated August 16, 2012, reports previous PT has been provided here w/ residual LBP. This request exceeds ODG which allows 9 visits over 8 weeks for neck pain and cervical spondylosis, 10 visits over 8 weeks for acute and chronic low back pain. There is no documentation of re-injury and there are no significant changes in physical exam findings. Re-initiation of supervised therapy this far out would be palliative in nature and would not be expected to significantly improve functional capabilities. Therapy guidelines for the apparent current diagnosis have already been met and for this reason remaining deficits should be addressed in a self-directed home program.”*

On September 27, 2012, Dr. noted that the patient continued to have cervical and low back pain which was above his normal baseline pain and had been present for the last several weeks to months. The PT was denied. The patient had to

increase his hydrocodone use to one tablet a day. Examination showed tenderness of the cervical paraspinal muscles and in the lumbar paraspinal muscles with some tightness and spasm in the lower lumbar and gluteal muscles. He had limited cervical ROM especially with rotation bilaterally to about 50% of normal. He had limited lumbar flexion to approximately 45 degrees and extension to 5 degrees. SLR produced pain radiating into the posterior thighs but not below the knee. His strength was +4/5 in the lower extremities and in upper extremities. Dr. opined that the patient would benefit from a short course of PT to hopefully bring his symptoms back down to his previous baseline that allowed him to take one hydrocodone tablet on average about three times a week.

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

Based on the medical records this injury occurred five years ago and there essentially has been little or no change in the physical findings. ODG recommends nine to ten physical sessions to be completed over eight to ten weeks. The request for twelve sessions exceeds ODG and the injury is five years old without evidence of a recent injury. Therapy at this point will of little or no lasting benefit and the decision is 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