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Notice of Independent Review Decision

DATE: November 12, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 97110, 97140, 97530, 97112, G0283 8 visits, 2 visits per week, 4 total weeks

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

The reviewer is certified by the American Board of Orthopaedic Surgery with over 40 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

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:

03/19/12, 04/30/12, 06/11/12, 07/30/12, 08/28/12, 10/09/12, 11/27/12: Office Visit
04/05/12: MR Right Elbow W/O Contrast, MR C Spine W/O Contrast, MR Right Shoulder W/O Contrast reports
05/15/12: EMG/NCS report
05/21/12: Arthrogram Right Shoulder/MRI Right Shoulder report
11/19/12: Operative Report
01/08/13: Initial PT Evaluation
01/08/13: Discharge Evaluation
02/05/13, 03/05/13, 04/02/13: Office visit
02/26/13: Precertification request
02/28/13: Physician Advisor Referral Form
03/04/13: Progress Note
03/07/13: MMI/IR
03/18/13: Functional Capacity Evaluation Initial
03/27/13: Prescribing Doctor's Statement of Medical Necessity
03/27/13: Physician Advisor Referral Form
03/28/13: Complete Rationale for Preauthorization Number: xxxxx

04/04/13: Initial Review
04/22/13: Work Comp Insurance Verification
04/24/13: Medical Contested Case Hearing
05/01/13: Hearing Decision
05/01/13: MRI Left Hip W/O Contrast report
05/14/13, 06/11/13, 07/23/13, 08/27/13, 09/24/13: Office visit
05/23/13: History and Physical
06/07/13: Prescribing Doctor's Statement of Medical Necessity for Drugs
06/24/13, 07/01/13: Request for Preauthorization
07/01/13: Notice of UR Request
07/08/13: Approval Determination – UR
07/23/13: Work Comp Pre-Auth Request Form
07/31/13: Notice of UR Request
07/31/13: Complete Rationale
07/31/13: Approval Determination – UR
08/05/13: Initial Evaluation/Plan of Care
08/07/13: Pre-Authorization Request
08/07/13: Notice of UR Request
08/08/13: Interim History and Physical
08/12/13: Adverse Determination – UR
08/12/13: UR performed
08/27/13: Appeal/Reconsideration of Adverse Determination
08/28/13: Acknowledgement of Request for Reconsideration/Appeal
08/29/13: Letter
09/12/13: Complete Rationale
09/24/13: Medication Preauthorization Request
09/24/13: UR Cover Sheet
09/27/13: Email
09/27/13: Adverse Determination – UR
09/27/13: Adverse Determination
09/27/13: Appeal/Reconsideration Determination – UR
09/27/13: Case Billing Invoice
10/08/13: Letter
10/08/13: Notice of UR Request
10/09/13: Independent Medical Consultation
10/09/13: Pre-Authorization Request Appeal
10/09/13: Appeal Request
10/28/13: Peer Reviewer UR Request

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his neck during a bicycle wreck on xx/xx/xx.

03/19/12: The claimant was evaluated. It was noted that he clipped a sign and crashed. He had immediate right elbow and shoulder pain with aggravation of a previous cervical injury. ASSESSMENT: Right shoulder subluxation, rule out impingement, capsular tear, rotator cuff tear. Contusion right elbow, rule out unstable fracture. Cervical pain secondary to aggravation previous injury. PLAN: MRI right shoulder. Continue full duty. RTC with MRI.

04/05/12: MRI C Spine W/O Contrast report. IMPRESSION: Central disc lesion at C5-C6, a small protrusion or bulge. The lesion abuts but does not deform the cord. Small central disc bulge at C6-C7 which indents the anterior thecal sac but does not abut the cord. No cord abnormality. No canal stenosis. No foraminal narrowing detected.

05/15/12: EMG/NCS. SUMMARY: Right C6 cervical radiculopathy, which is both acute and chronic in nature. No evidence of left cervical radiculopathy, other focal compression neuropathy, brachial plexopathy at this time.

11/09/12: Operative Report. ADMISSION DIAGNOSIS: Impingement syndrome of the right shoulder with a superior labrum anterior and posterior lesion. PROCEDURES: Acromioplasty. Distal clavicle resection. Repair of rotator cuff with intrasubstance tear. Repair of superior labrum anterior and posterior lesion of the anterior/superior glenoid with a corkscrew device.

02/05/13: The claimant was evaluated for neck and arm pain. He complained of constant pain in his neck and radiation arm pain. He had bilateral arm/hand tingling that was periodic. The neck pain was constant. On exam, he had a normal reciprocal gait. Cervical ROM: Flexion 0-70, extension 0-50, right rotation 0-40, left rotation 0-40. Strength was 5/5. Reflexes were 1/3 at the biceps, triceps, and brachioradialis bilaterally. Sensation was intact in the bilateral upper extremities. Distraction test was negative. Compression test was negative. ASSESSMENT: C5-C6 and C6-C7 disc herniation with radiculopathy worsening symptoms. Status post right shoulder SLAP repair, labral repair, acromioplasty, distal clavicle resection. PLAN: Begin therapy. Continue meds Tramadol, Skelaxin, lidocaine patches, and Mobic. RTC 8 weeks.

03/04/13: The claimant was evaluated for the right shoulder. ASSESSMENT: He continues to progress well with therapy interventions. His strength is improved, pain and soreness is decreased, and endurance is improved. Recommend FCE and return to work.

04/02/13: The claimant was evaluated for complaints of continued neck and right shoulder pain. On exam, his motor strength was 5/5. Reflexes were 3/3 at the bilateral upper extremities. Sensation was normal in the bilateral upper extremities. PLAN: Precert C5-C6 and C6-C7 ACDF. Appeal denial of Skelaxin and Lidoderm. Continue meds.

04/24/13: Decision and Order: Claimant is not entitled to an inpatient surgery for C5-C6 and C6-C7 anterior cervical discectomy and fusion and spinal monitoring for the compensable injury of xx/xx/xx.

05/23/13: The claimant was evaluated for cervical pain. His medications included Mobic, Metaxalone, gabapentin, Tramadol, and simvastatin. On exam, he was tender over the left C5-C6 and C6-C7 facet with 70 degrees right and left cervical rotation, 10 degrees cervical flexion, 10 degrees cervical extension, and 10

degrees right and left cervical side bending. Motor testing was 5/5.
ASSESSMENT: Right C6 cervical radiculopathy EMG evidence. Cervical MRI in April 2012 showing central disc lesion C5-C6, C6-C7 with C5-C6 abutment against the spinal cord, C6-C7 indentation anterior thecal sac. TREATMENT PLAN: Cervical epidural block #1 targeting C5-C6 level under fluoroscopy with epidurogram.

08/05/13: The claimant was evaluated by PT for cervical pain. He complained lower cervical spine pain radiating into the shoulders and bilateral 5th and 6th fingers. He rated his pain at 6/10 at worst and 3/10 at best. It was noted that he reported having an epidural a couple of weeks prior and that he would "never have another one." It was noted that he had previously received therapy to his neck at a different location. He demonstrated decreased ability to perform full AROM of the cervical spine. His PROM was within normal limits for bilateral rotation and side bending, but had moderate-severe pain with increase motion. TREATMENT PLAN: 2 times per week x 4 weeks.

08/08/13: The claimant was evaluated for cervical pain. It was noted that he had a cervical epidural block #1 targeting the C5-C6 level on 07/16/13. He stated that there was no benefit or reduction in pain. He actually had increased flare pain for a two-week time frame. On exam, right cervical rotation 50 degrees, left cervical rotation 60 degrees, 20 degrees cervical flexion, and 15 degrees extension, 10 degrees right and left cervical side bending. Motor testing 5/5. Right and left suprascapular tenderness. PLAN: There was no improvement after first cervical epidural injection, and I would not repeat.

08/12/13: UR. RATIONALE: The claimant is a male who sustained neck injury on xx/xx/xx. The claimant complains of lower neck pain that radiates into shoulders. The pain is rated 6/10. The pain is aggravated by prolonged upper extremity activity, lifting, and prolonged upper extremity use. The claimant previously received PT on neck at a different location. The claimant reports decreased functional ability to complete essential functions required in work environment. On exam, there is decreased cervical range of motion due to pain and decreased muscle strength to 4+/5. The provider recommends PT 2 times a week for 4 weeks including CPT codes 97110 (ther ex), 97140 (manual th), 97530 (ther activities), 97112 (neuro muscular re-ed), and G02183 (estim unattended). ODG-TWC Neck and Upper Back Procedure Summary identifies best practice physical therapy guidelines for cervical strain (WAD) as 10 visits over 8 weeks. In this case, the provider has requested PT for the cervical spine. However, submitted medical records note that the claimant previously received PT on the neck and there is no clear indication whether the claimant has responded well with prior treatment to warrant the request. Moreover, there is limited evidence of recent exacerbation or re-injury to warrant the request. In addition, the claimant's injury is more than one year old and the claimant is expected to be well versed in an independent home exercise program to address remaining deficits and guidelines do not support the use of electrical stimulation for treatment of neck pain. Thus, the medical necessity for PT is not established.

08/27/13: The claimant was evaluated for continued neck pain. On exam, cervical ROM: flexion 0-70, extension 0-60, right rotation 0-60, left rotation 0-60. Motor testing was 5/5. Reflexes: Biceps, triceps, brachioradialis 3/3 bilaterally. Sensation intact in bilateral upper extremities. DATA: MRI dated 08/07/13 was significant for disc bulges at C4-C5 and C5-C6, left foraminal stenosis at C5-C6 secondary to disc bulge, no central stenosis. ASSESSMENT: Cervical pain secondary to aggravation previous injury, C5-C6, C6-C7 disc herniation with cord abutment positive C6 radiculopathy. PLAN: Will precert C5-C6 ACDF. Continue meds. RTC 4-6 weeks.

08/27/13: Appeal by Physical Therapy. "We had originally requested 18 physical therapy visits to treatment the claimant's neck. This request was sent to peer review and denied due to ODG and that ODG only allows 10 visits and that in our initial evaluation note, we wrote that 'Patient received physical therapy on his neck at a different location.' I am appealing with a corrected note because the patient had previous PT on his neck under a different injury and claim. That claim has since been closed out. The claimant has not had any physical therapy on his neck under this current claim FW-12400470 DO 1-19-12. He has only had treatment to his shoulder and not neck. I have attached the amended PT note, the order for PT, a new updated auth request form, the denial and a note. I ask that you reconsider authorization for physical therapy to the neck. I have attached an updated authorization form requesting 8 visits (2 times a week for 4 weeks) including CPT codes 97110 (therapeutic ex), 97140 (manual therapy), 97530 (therapeutic activities), 97112 (neuro-muscular re-ed), and G0283 (e-stim unattended)."

08/29/13: Letter. "has had physical therapy request for cervical spine denied with the reviewer not having clear information per the denial rationale as to why the therapy was requested. The reviewer states, 'there is no indication whether the claimant has responded well with prior treatment to warrant the request.' The reviewer does not disclose what he actually reviewed to reach this conclusion because the rationale is clearly stated in clinic notes as well as in therapy notes that Mr. has continued neck and radicular arm pain for which he is treating. The reviewer has absolutely no information from which his decision was based, and with ODG appropriate need existing the reviewer's denial is invalid. There was no basis in evidence-based Medicare that supports the denial. Contrary, the clinic and therapy notes do comply with the request for therapy and this should be upheld."

09/12/13: UR. RATIONALE: Based on treatment guidelines up to nine physical therapy visits over an eight week period of time are supported for Cervicalgia. Up to 10-12 visits are supported for degenerative disc disease of the cervical spine, while 10 visits over an 8-week period of time are supported for a sprain/strain of the cervical spine. The claimant's injury dates back to xx/xx/xx. There is conflicting evidence as to whether or not physical therapy has been accomplished at the neck region. The physical therapy evaluation from 08/05/13 documented that the claimant has undergone a previous epidural steroid injection and also underwent previous physical therapy for the neck at another facility. At this time,

the claimant is well over a year out from the original injury date. There is no documentation of significant functional deficits that would support the ongoing medical necessity of a formal physical therapy program at this time based on the range of motion measurements and strength in the bilateral upper extremities. Again, treatment guidelines support treatment for a time frame of eight weeks following an injury and we are well outside of that time frame at this point. The claimant should be well versed on a self-directed home exercise program and, again, there is no significant deficit to support the medical necessity of formal physical therapy. The previous no-certification was reviewed and based on the fact that the claimant had undergone previous physical therapy with unknown response to treatment. It was stated that there was no documented exacerbation or re-injury to support the medical necessity of formal physical therapy, and the injury was greater than one year old. The treating provider has presented additional information including a letter requesting appeal on 08/27/13. The treating provider indicated that the claimant had had previous physical therapy on the neck under a different injury and claim which has since been closed out. The claimant has not had any physical therapy for the neck under the current claim. The claimant was noted to have a prior history of treatment to the shoulder and not the neck; and, therefore, an appeal request was made. The treating provider's appeal letter does not result in an overturn of the previous non-certification. The claimant has had previous physical therapy to the neck and should be well versed in a home exercise program. There is no significant functional deficit. The additional information does not result in an overturn. The previous non-certification is supported.

09/24/13: The claimant was evaluated. It was noted that he had cervical ESI at C5-C6 that did not help him. It was also noted that he "has never had therapy for his cervical injury but has not yet started therapy at this time." On exam, cervical ROM: flexion 0-70, extension 0-60, right and left rotation 0-60. Strength 5/5. Sensation normal. PLAN: Continue meds of Tramadol, Skelaxin, Motrin, and lidocaine patch. See for IME and second opinion. RTC 4-6 weeks.

10/08/13: Letter. "Mr. has had request for therapy denied on the basis that he is 'outside of that time frame at this point,' referring to the fact that therapy should be initiated 8 weeks or sooner after injury. The facts are that he has a cervical injury with herniated cervical discs and positive EMG for cervical radiculopathy that currently continues to be symptomatic with neck and shoulder/arm pain. Therapy is indicated to treat these complaints and findings that either completes treatment to symptom resolution or indicates the next line of treatment. Denying treatment based on proximity of injury and/or technical grounds is invalid because it does not address the medical evidence in this patient with herniated cervical discs and positive EMG."

10/09/13: The claimant was evaluated for Medical Consultation for ODG and clinical rationale for physical therapy and for C5-C6 anterior fusion. IMPRESSION: C5-C6 disc protrusion verified by objective radiology. Resulting cervical radiculopathy by EMG and radiculopathy by reflex findings on examination. DISCUSSION: The patient has not received his PT because it has

been denied by the carrier, which is unbelievable in this case because the gentleman is entitled to therapy for his cervical lesions. ODG support physical therapy for this. The guidelines suggest 10 visits over 8 weeks minimally. Medical treatment suggests 10 visits over 8 weeks. Degenerative disease is 10-12 visits over 8 weeks. For this reason, Mr. is entitled to the physical therapy. I know the carrier tried to define it back to an earlier injury, but this injury has not been treated as it should be. In my medical opinion, based on the official guidelines, this patient is a candidate for at least a single-level fusion at C5-C6. In addition, Appendix D of ODG applies in this case: individual consideration of durations and treatment due to comorbid and degenerative conditions, as well as severity and failure to improve. Therefore, I concur recommendation for additional therapy. He may ultimately benefit from a chronic pain rehabilitation program, due to the duration and severity of the compensable conditions.

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

The previous adverse decisions are overturned. There is some discrepancy as to whether or not the claimant has had previous physical therapy to the neck. A mention was made in a physical therapy note that he had previous physical therapy at another facility in the past. However, that treatment was for a previous injury not related to this claim. There is no documentation submitted to indicated that he has undergone physical therapy for his neck. ODG allows 10 visits of physical therapy over 8 weeks for the treatment of displacement of cervical intervertebral disc, which is the findings in this case. The claimant has an MRI that shows a C5-C6 disc protrusion. Therefore, the claimant meets the ODG criteria and the request for PT 97110, 97140, 97530, 97112, G0283 8 visits, 2 visits per week, 4 total weeks is found to be medically necessary.

ODG:

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| Physical therapy (PT) | <p><i>ODG Physical Therapy Guidelines –</i></p> <p>Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial".</p> <p>Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0): 9 visits over 8 weeks</p> <p>Sprains and strains of neck (ICD9 847.0): 10 visits over 8 weeks</p> <p>Displacement of cervical intervertebral disc (ICD9 722.0): Medical treatment: 10 visits over 8 weeks Post-injection treatment: 1-2 visits over 1 week Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 weeks</p> <p>Degeneration of cervical intervertebral disc (ICD9 722.4): 10-12 visits over 8 weeks See 722.0 for post-surgical visits</p> <p>Brachia neuritis or radiculitis NOS (ICD9 723.4): 12 visits over 10 weeks See 722.0 for post-surgical visits</p> |
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| | <p>Post Laminectomy Syndrome (ICD9 722.8): 10 visits over 6 weeks</p> <p>Fracture of vertebral column without spinal cord injury (ICD9 805): Medical treatment: 8 visits over 10 weeks Post-surgical treatment: 34 visits over 16 weeks</p> <p>Fracture of vertebral column with spinal cord injury (ICD9 806): Medical treatment: 8 visits over 10 weeks Post-surgical treatment: 48 visits over 18 weeks</p> <p>Work conditioning (See also Procedure Summary entry): 10 visits over 8 weeks</p> |
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**