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Notice of Independent Review Decision

Date: July 14, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Initial physical therapy for the thoracic spine with evaluation, two times a week for four weeks as an outpatient

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

Diplomate American Board of Orthopaedic Surgery
Fellowship Trained in Spine Surgery

REVIEW OUTCOME:

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was walking around. She turned and twisted and felt acute pain in the medial border of the scapula, going into the neck and down the upper arm to the elbow with some tingling.

On xxxxx, physical medicine and rehabilitation, evaluated the patient for cervical pain radiating down the left arm. The patient also had left periscapular pain and left arm pain. Following the injury, the patient had immediately gone to Medical Clinic and attempted some physical therapy (PT). It actually increased her symptoms. She went for at least six visits. She reported it was bothersome to

her. She reported she underwent trigger point injections (TPIs) too along the upper trapezius which did not seem to help. She stated it made her sick. It included 80 mg of Depo-Medrol. She also tried some oral prednisone. She rarely took tramadol at home. She was still working with restrictions full time as a supervisor. It did wake her up at night, particularly if she would look up for a prolonged period of time and lot of sharp shooting pain that referred left medial border in the scapular region. She reported having x-rays but no magnetic resonance imaging (MRI). Examination of the cervical spine showed palpatory tenderness at the cervicothoracic junction. Repetitive extension and Spurling's included medial border scapular pain on the left. There was severe pain upon the inferomedial border of the scapular particularly along the lower rhomboid as well as on the serratus anterior region that referred up to upper arm area. She had mild shoulder abduction weakness with dysesthesias that went in the upper arm to the elbow posteriorly. felt there was possible cervical nerve root irritation. Also there could be lower rhomboid and serratus myofascial triggering, particularly with ropiness upon palpation occurred up to the cervical spine. Diagnosis was pain in thoracic spine. recommended MRI of the cervical spine to look nerve root irritation, particularly disc herniation on the left side particularly at the C5 or C6. recommended work restrictions and continued the patient on current medication regimen including Mobic, metaxalone and tramadol.

On May 21, 2014, MRI of the cervical spine showed broad left paracentral disc protrusion at C6-C7 causing left neural foramen stenosis and compression of the left C7 nerve root. There was tiny posterocentral disc protrusion at C5-C6 with no central or foraminal stenosis. Structures of the posterior fossa and cervical cord were unremarkable. There was no acute fracture or bone contusion.

On May 29, 2014, evaluated the patient for thoracic spine pain. reviewed the MRI findings that showed left C6-C7 disc protrusion impinged on left C7 nerve root most likely correlating to her symptoms. That was probably why the PT initially did not help. They were doing lot of periscapular soft tissue working on her cervical spine. Examination showed positive Spurling's on the left inducing severe medial border scapular pain with palpatory pain with tenderness up that area with modified traction reduced her symptoms significantly in the medial border of the scapula and upper arm area. She had dysesthesias posterior arm. She had mild triceps strength particularly with doing a one arm pushup against the wall standing up. felt the left C6-C7 disc protrusion most likely were the correlating the symptoms. Diagnosis was pain in thoracic spine. Cervical epidural steroid injection (ESI) was discussed. referred the patient for PT. He recommended changing the PT with retraction to focus on her cervical spine.

Per utilization review dated June 5, 2014, the request for eight initial PT sessions for the thoracic spine with evaluation, two times a week for four weeks as an outpatient was denied based on the following rationale: *"This is a female who was injured on xx/xx/xx. The most recent progress note, dated May 29, 2014, indicates the injured worker presents with left-sided back, shoulder, and neck pain. The clinician notes that physical therapy previously did not provide any relief, and a recent MRI of the cervical spine shows a disc protrusion at C6-C7*

impinging on the exiting left C7 nerve root. The physical exam documents a positive Spurling's sign on the left with severe medial border scapular pain and pain with tenderness to palpation with modified traction. An examination is not performed on the thoracic spine. The ODG supports the use of physical therapy in the management of sprain/strains of the back. Based on the clinical documentation provided, there are no subjective or objective findings consistent with thoracic pain. As such, the request is considered not medically necessary and is recommended for non-certification."

On June 19, 2014, the patient underwent PT evaluation. The patient presented with severe cervical and left upper extremity symptoms. The patient presented with constant elevated neck and arm pain. The patient presented with positive Spurling's bilaterally, left greater than right. There was limited cervical range of motion (ROM) due to pain, decreased left upper extremity ROM due to pain. There were increased left upper extremity radicular symptoms. The patient's tolerance with exercises was limited. The patient would be worked on pain management and she would be advised exercises as tolerated. Modalities would include moist hot pack, cold pack and interferential current.

Per the reconsideration review dated June 26, 2014, the appeal for eight initial PT sessions for the thoracic spine with evaluation, two times a week for four weeks as an outpatient was denied based on the following rationale: *"A female with the date of injury of xx/xx/xx. The compensable body part is the thoracic spine. The request is for initial physical therapy for the thoracic spine two times a week for four weeks. I attempted to reach the requesting physician. I left a voice message on his cell and did not receive a callback. The medical records do not indicate any evidence of any orthopedic, neurologic or functional impairment. At this time the request for physical therapy for the thoracic spine is recommended for non-certification as being not medically reasonable or necessary."*

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

This patient apparently turned and twisted and allegedly felt pain into the upper back and scapular region. She presented then to Medical Clinic although there are no records from Medical Clinic for review. The patient underwent six sessions of PT although there is suggestion that the therapy made the symptoms worse. The patient also underwent trigger point injections without any significant benefit. On May 8, 2014, noted the patient's history as well as the symptoms currently to include increased symptoms with looking up and the symptoms were also awakening her at night. On exam, there is tenderness into the cervicothoracic junction as well as pain into the inferomedial border of the left scapula. There was noted mild shoulder abduction weakness. considered her symptoms were possibly related to the cervical spine and a nerve root irritation and ordered a cervical spine MRI looking at the C5 and C6 levels specifically.

On May 21, 2014, the MRI of the cervical spine read showed a disc protrusion at C6-C7 with a neuroforaminal narrowing on the left with likely compression of the C7 nerve root.

On May 29, 2014, reviewed the MRI findings noting that the C7 impingement likely correlated with her symptoms.

There was again no range of motion assessment or provocative shoulder testing such as impingement sign, empty can sign etc.

did propose that a cervical epidural steroid injections would be a consideration.

On June 5, 2014, the patient underwent the first utilization review for the eight sessions of physical therapy for the thoracic spine. The request was denied based on the lack of correlation of the report of thoracic pain with the patient's clinical exam and condition.

On June 19, 2014, there was PT evaluation completed. Of interest in the handwritten note the left shoulder range of motion on forward flexion was 65 degrees and the abduction was 52 degrees strongly suggesting a significant shoulder issue or pain inhibition of significance.

A second precertification was completed on June 26, 2014. As noted there was no orthopedic neurological functional impairment identified.

Thus, the overall records do not support that there is a thoracic injury that needs to have formal therapy that could not be done already at home. In addition, the symptoms even were focused more towards the cervical spine. As noted on the 6-19-14 therapy note there was decreased range of motion of the left shoulder, which may be a contributing factor here. Thus the therapy for thoracic spine would not appear to be a medical necessity supported by the ODG given the clinical records and localization of the pain as documented by the therapist, but even.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES