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Notice of Independent Review Decision

December 30, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 3 x week x 6 weeks, lumbar spine (97110, 97140)

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

Physical Medicine and Rehabilitation Physician

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.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female. On xx/xx/xx, she sustained an unknown injury to her back.

2011 – 2013: On January 25, 2011, evaluated the patient for low back, right buttock and hip and leg pain. The pain was described as burning and cramping. The lower back pain accounted for 70% of pain and radiated to the right buttock to the legs posteriorly on the right. The pain was intermittent and worsened with coughing/sneezing, with straining during bowel movement, with standing, with walking and relieved by lying down and sitting. She also complained of muscle spasm bilaterally, buttock/hip muscle cramps on the right, muscle cramps in the right thigh, right leg pain accounted for 30% of pain in the calf and calf muscle cramps in the right calf. The patient also reported that her right lower extremity and back fatigued easily. Analgesics, nonsteroidal anti-inflammatory and muscle

relaxants provided short-term improvement. Examination of the lumbar spine showed spasms of the paraspinal muscles bilaterally, abnormal range of motion (ROM) with pain and positive straight leg raising (SLR) on the right. reviewed a magnetic resonance imaging (MRI) of the lumbar spine that was performed and diagnosed bulging disc, herniated disc, lumbar spondylosis without myelopathy and lumbar radiculopathy. He recommended lumbar epidural steroid injection (ESI).

On January 26, 2011, performed lumbar therapeutic ESI via caudal approach.

On February 7, 2011, noted the patient had 50% improvement of symptoms since the last procedure. She had increased pain after making a bed. She still reported 30% improvement. recommended lumbar ESI.

On February 10, 2011, performed lumbar therapeutic ESI via a caudal approach.

On August 8, 2011, an MRI of the lumbar spine showed 5 mm right subarticular zone disc extrusion at L5-S1, status post partial discectomy and right hemilaminotomy. There was persistent posterior displacement of the exiting right S1 nerve root, less pronounced than on the preoperative exam. Expected enhancing granulation tissue along the operative soft tissues and right lateral recess was present. There was slight disc bulging and facet hypertrophy at L4-L5 without central canal stenosis.

On April 10, 2012, evaluated the patient for chronic back pain. The medial branch blocks were denied. opined the patient could consider fusion suggested. The patient reported that she was managing her pain when it flares with transcutaneous electrical nerve stimulation (TENS) unit, Biofreeze and lidocaine. Examination revealed slightly decreased sensation in the posterolateral calf on the right compared to the other locations on the right lower extremity and compared to the left which were otherwise normal. There was positive seated slump SLR on the right with radicular complaint down the right leg in the posterolateral thigh, calf and towards the right ankle/heel. continued TENS unit, Biofreeze and lidocaine.

On May 22, 2012, noted low back and right leg pain. The patient reported 50-50 leg to back pain, a sense of numbness in the right posterolateral calf, aching down the leg into the right posterolateral calf and aching in the lower back. MRI had showed disc extrusion extending 11 mm x 5 mm at the L5-S1 level on the right side with the disc extrusion extending into the right subarticular zone. The right S1 nerve root also was effaced and displaced slightly. Examination revealed tenderness in the lumbosacral spine at L5-S1 level and towards the right gluteus. There was tenderness in the right sciatic notch. SLR was positive on the right at 45 degrees with pain radiating all the way down into the right calf. The patient reported a slight strange sense which felt slightly different in the posterolateral calf on the right compared to elsewhere. diagnosed right L5-S1 disc extrusion with right L5 versus S1 radiculopathy/radiculitis. The patient was still reluctant to have surgery. She was a candidate for a fusion but would prefer a disc replacement

surgery given its lower risks of problems down the line. She was too osteoporotic at that moment and was getting injections of Prolia to try to improve her bone density. continued Biofreeze and lidocaine, provided sample of Cymbalta and recommended ESI.

On June 20, 2012, noted the injection was not approved yet. prescribed Zanaflex.

On July 30, 2012, performed a designated doctor exam (DDE) and opined the patient had not reached maximum medical improvement (MMI). further opined the patient had a recurrent herniated nucleus pulposus (HNP) at L5-S1 with minimal scar tissue in the right L5-S1 lateral gutter. He recommended transforaminal ESI at L5-S1 on the right and if unsuccessful considering a repeat discectomy at L5-S1 with no fusion.

On September 4, 2012, noted ongoing back pain. Examination revealed restricted lumbar ROM, bow string was positive and ankle dorsiflexion was positive, pain with both SLR and seated SLR. SLR pain was located at buttocks, thigh and lower leg. Seated SLR pain was located at buttocks, thigh and lower leg. diagnosed chronic right low back and right lower extremity radicular pain with L5-S1 recurrent herniation at that level irritating the nerve. The patient had moderate-to-severe pain which was modestly reduced with her topical cream and Cymbalta. She felt she was definitely better with these medications than without them. refilled medications and recommended ESI.

On September 24, 2012, performed right L5 transforaminal ESI.

On October 17, 2012, evaluated the patient for back pain and leg pain. The patient wanted to get another injection. Ms. noted 50% improvement since L5-S1 ESI. She requested a transforaminal ESI.

On November 12, 2012, performed right L5 transforaminal ESI.

On December 4, 2012, noted back pain and leg pain. The patient reported 80-90% relief for first 8-9 days. She was still unable to sit for long but after her injection she was able to sit much longer. The patient had moderate-to-severe pain and secondary depression. She had stopped Cymbalta. Surgical referral was provided for severe chronic back and leg pain related to her L5-S1 recurrent disc herniation.

A bone mineral density study on December 5, 2012, determined the patient to be osteoporotic with high fracture risk.

On January 15, 2013, noted a history of lumbar laminectomy on January 15, 2011. diagnosed right-sided low back and right leg pain with evidence of recurrent HNP at L5-S1. She ordered MRI of gadolinium and opined the patient was a candidate for a revision discectomy.

On January 28, 2013, an MRI of the lumbar spine showed right lateral recess disc protrusion at L5-S1 that had decreased slightly in size since the prior study; however, continued to displace the exiting right S1 nerve root posteriorly. There was stable mild-to-moderate right neural foraminal narrowing. There was stable mild disc bulging and associated neural foraminal narrowing at L3-L4 and L4-L5.

On February 6, 2013, noted that the adjuster had requested for impairment rating (IR) as the patient had reached statutory MMI as of January 29, 2013.

On February 6, 2013, electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities showed no evidence of acute/subacute/ongoing right lumbar radiculopathy. There was a small amount of spontaneous activity seen at L5-S1 in the paraspinals but given the small amplitude it was likely reflective of post surgical changes although this could represent findings of a lumbar radiculopathy as well. The slight increase in amplitude/polys seen in the right gastroc could be reflective of a mild S1 radiculopathy that was no longer showing findings of ongoing denervation.

On February 8, 2013, noted the patient had back pain and leg pain located on the right side. Examination revealed tenderness of the right buttock. recommended revision discectomy at the L5-S1 level.

On February 26, 2013, noted ongoing right buttock and right calf pain. discussed upcoming procedure.

On February 28, 2013, performed revision, right L5-S1 hemilaminectomy, lysis of adhesions, excision of herniated nucleus pulposus at L5-S1 with foraminotomy and application of amniotic membrane as a scar and adhesion barrier.

On March 11, 2013, evaluated the patient and noted ongoing right leg pain. SLR was positive at 45 degrees on the right. There was pain with seated SLR located at lower leg. recommended starting physical therapy (PT).

On April 1, 2013, the patient underwent PT evaluation. She was recommended therapy two times a week for four weeks. She had attended five sessions. The patient was recommended continuing PT.

On April 3, 2013, noted the patient was going to PT which was helping her. Ms. felt the patient would benefit from work conditioning program (WCP) and recommended considering functional capacity evaluation (FCE). The patient was maintained on Zanaflex, Flexeril and Lortab.

Per progress note dated April 29, 2013, the patient had attended 12 sessions of PT.

In an FCE dated May 2, 2013, the patient lacked lifting tolerance and was recommended WCP four hours a day for five days for two weeks.

On May 17, 2013, the patient underwent work conditioning session.

On May 20, 2013, noted the patient continued having good days and bad days. She was noticing more good days than bad. There was ongoing right leg discomfort but it was significantly better than prior to surgery. She was attending WCP and was doing well. Ms. felt the patient had done well in her WCP and was ready to return to work without restrictions.

On July 19, 2013, noted increasing right-sided low back pain as well as pain in the leg that was rated as 6/10. The patient reported she was getting depressed from this. Examination revealed tenderness over the right sacroiliac (SI) joint and sciatic notch area. Sitting root test produced right leg pain. ordered MRI.

On July 29, 2013, MRI of the lumbar spine showed status post right-sided laminectomy at L5-S1 and enhancing granulation tissue within the right lateral aspect of the spinal canal at the L5-S1 level surrounding the right S1 nerve root sleeve and 2 mm annular bulge at L2-L3. There were 2 mm posterior disc protrusions at L3-L4 and L4-L5.

On July 30, 2013, noted increasing low back pain as well as some pain into leg. prescribed Lyrica and recommended ESI.

On August 8, 2013, evaluated the patient and noted that she scored 28 on CES-D consistent with moderate to significant depression and 14 on BAI consistent with mild anxiety. opined the patient was reactively depressed in response to the continued pain and disability. She had some maladaptive thinking patterns associated with her pain, primarily catastrophizing. further opined that the patient could benefit from psychotherapy, but was not motivated for this. Depression was risk factor for reduced spine surgery results and increased pain sensitivity.

On September 10, 2013, performed caudal ESI.

On October 16, 2013, noted that exercises were helping the patient. Sitting root test caused minimal pain on the right. diagnosed lumbar post laminectomy syndrome; HNP, protrusion, extrusion; lumbosacral neuritis or radiculitis and lumbar intervertebral disc without myelopathy.

2014: Per a bone mineral density study dated January 13, 2014, the patient was considered osteoporotic with high fracture risk.

On January 21, 2014, noted low back pain on the right side radiating into the right leg. opined the patient was not a candidate for disc replacement as she was osteoporotic.

From April 22, 2014 through June 25, 2014, the patient attended therapy.

On May 7, 2014, noted the patient to have a negative sitting root test on the right and the left but with some pain. recommended therapy and gave a trial of diclofenac.

On June 6, 2014, provided a letter of medical necessity for diclofenac.

On June 30, 2014, provided a letter of medical necessity for continued PT and dry needling. The patient had been approved eight sessions and was getting good relief from the appointments with the therapist although only lasting about three days. The patient was status post laminectomy/discectomy on February 28, 2013, with residual right leg pain. The patient wanted to continue to work as it was beneficial to strengthen the muscles along with a good core program that could help her maintain activities of daily living.

On July 8, 2014, performed a peer review. He noted that had performed emergent right L5-S1 microdiscectomy, laminectomy and foraminotomy with ESI on March 21, 2011. Postoperative diagnosis was large herniated disc on the right at L5-S1. rendered the following opinions: (1) ODG would support the patient returning to full duty work, home exercise, over-the-counter (OTC) analgesics and occasional use of OTC nonsteroidal. ODG would also support follow-up with the orthopedic surgeon in the event of an acute flare up in symptoms. The patient had completed postoperative therapy and ODG would not support additional therapy, DME products such as TENS unit, injections or pain management. (2) ODG would not support additional active treatment. The patient had undergone appropriate postoperative formal therapy per ODG after the February 28, 2013 surgery and no additional active therapy would be reasonable at that time. The ODG defines dry needling as either acupuncture or trigger point injections. The ODG would only support acupuncture for 3 to 4 visits on conjunction with other active interventions. ODG would not support acupuncture stand alone treatment as related to the xx/xx/xx, work event. (3) The patient was not a candidate for disc replacement though may be a candidate for a lumbar fusion. The ODG would not support a lumbar fusion as related to the xx/xx/xx work event that did not produce acute instability. The ODG would not support disc replacement. (4) The ongoing use of nonsteroidal was not supported by ODG. The diclofenac could be abruptly discontinued. The ODG would support OTC nonsteroidal for occasional use only if effective.

On July 9, 2014, noted ongoing constant pain in the right lower back and leg. opined the patient would benefit from dry needling and further therapy. He recommended evaluation for possible spinal cord stimulator.

On August 4, 2014, evaluated the patient for bad history of failed spine surgery. discussed spinal cord stimulator versus needling and referred her to a psychiatrist.

On September 15, 2014, the patient was evaluated and was recommended continued therapy once a week for six weeks to progress work tolerance and endurance.

Per utilization review dated October 20, 2014, the request for PT was denied with the following rationale: *“The patient is a female who sustained a twisting injury to the low back on xx/xx/xx. She is diagnosed with post-laminectomy syndrome of lumbar region, lumbosacral neuritis or radiculitis, unspecified and displacement of lumbar intervertebral disc without myelopathy. A request is made for 18 sessions of PT to the lumbar spine. History is significant for hemilaminectomy and discectomy on February 28, 2013. The patient has had acupuncture, ESIs, and work conditioning in the past as per peer review July 8, 2014. Note that there was no recent clinical evaluation from the requesting provider, assessing the patient's current complaints, functional status, medications and treatment response. In his letter of medical necessity dated June 30, 2014, the patient has 8 approved sessions of PT. The total number of completed PT sessions to date and the patient's objective function response to therapy was not provided. At this point, the medical necessity of the request for 18 sessions of PT to the lumbar spine cannot be established.”*

On October 29, 2014, noted felt the patient was a candidate for spinal cord stimulator. The patient had decided not to do that. The patient was unable sit or stand for long time. The patient felt local treatment seemed to do best for example dry needling and creams over the areas of tenderness. Examination revealed sitting root test on the right was productive of right-sided low back and lump sum leg pain. recommended dry needling and provided diclofenac as a topical analgesic cream.

Per reconsideration review dated November 19, 2014, the appeal for PT was denied with the following rationale: *“The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The mechanism of injury was not provided. A current medication list was not submitted. There was no mention of surgical history or diagnostic studies listed. Other therapies included physical therapy. The patient is a female who reported an injury on xx/xx/xx. Her diagnoses were post-laminectomy syndrome of the lumbar spine, lumbosacral neuritis or radiculitis (unspecified), and lumbar intervertebral disc without myelopathy. The provider recommended physical therapy three times per week times six weeks for the lumbar spine. The guidelines note that physical therapy is recommended and there is strong evidence that physical methods (including exercise and return to normal activities) have the best long term outcome in patients with low back. The guidelines recommend ten visits of physical therapy over eight weeks for intervertebral disc disorders without myelopathy. The documentation provided lacked evidence of objective functional deficits that needed to be addressed with the use of physical therapy. There was no documentation on the efficacy of the prior physical therapy visits the patient underwent and there is no evidence of how many physical therapy visits the patient has completed. There were no significant barriers to transitioning the patient to an independent home exercise program. Therefore, the medical necessity has not been established.”*

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

Upon review of treatment notes claimant is s/p post surgical PT at least 18 visits and has also undergone work conditioning. Claimant should be well versed regarding the use of a daily HEP after completing the noted formalized therapy since her surgery. There is no report regarding acute injuries or acute measured significant functional deterioration that would support the need of additional PT versus the use of a daily HEP. There is no appreciation in the treatment notes depicting long term objective measured functional gains from the most recent series of PT x 8 sessions. The request also exceeds ODG guidelines regarding number of post surgical visits as well.

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