

CASEREVIEW

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[Date notice sent to all parties]: May 21, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

6 sessions of Aquatic and Physical Therapy for the Cervical Spine:

97010 Heat/Cold Therapy 15 min

97110 Therapeutic Exercise

97112 Neuromuscular Re-education

97113 Aqua Therapy with Therapeutic Exercises

97140 Manual therapy techniques; ea. 15 min

97150 THER PX GRP 2/> INDIVS

97530 Therapeutic Activities 15 min

G0283 G-Stimulation

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 16 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

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 claimant is a female who was injured while working on xx/xx/xx. She was turning a corner in a hallway and started being punched several times. She was hit in the face/head and upper body and complained of neck pain, left shoulder pain and upper back pain. She also reported loss of consciousness. She was initially seen in the ER where CT of the C-spine and X-rays of the C-spine and Left Shoulder were performed. She was diagnosed with cervical sprain and facial/scalp contusion and then discharged with a prescription of Clonazepam. She then sought treatment who recommended physical therapy, moist heat to

neck 2-3 times daily and OTC medications as needed. She completed at least 10 session of PT from March 31, 2014 through May 1, 2014. She continued to have complaints of frontal headaches described as sharp, moderate and lasting for more than 30 days. Lortab and Zanaflex were prescribed. She continued with neck pain with radiation to the right upper extremity. Past medical history was positive for ACDF. Therefore, she was referred to a neurosurgeon for surgical consultation by. She presented to the ER on multiple occasions with severe pain.

On May 8, 2014, MRI of the Cervical Spine, Impression: 1. Large Central C4-5 disc herniation with spinal stenosis and nerve compression. Disc bulge to the right present also. 2. Small right C6-7 paracentral disc protrusion. Cord flattening but no cord compression in this position. 3. C5-6 anterior fusion without complication.

On June 2, 2014, the claimant presented with neck pain radiating into the right upper extremity into the shoulder along the lateral arm into the fingers of the right hand with associated numbness and tingling that was constant as well as intermittent weakness of the right upper extremity. She also complained of frontal headaches on a daily basis and dysphagia that comes and goes. She is status post physical therapy and epidural steroid therapy with no improvement. Pain was described as 9-10/10. History was positive for previous injury to the neck in 2012 that subsequently underwent an anterior cervical discectomy and fusion at C5-6 with placement of anterior cervical plate by. She reported that her symptoms had abated and she had no problems until the work related injury on xx/xx/xx. On examination her cervical ROM was markedly restricted in lateral rotation secondary to pain. Motor exam revealed 4/5 strength in the right UE. Deep tendon reflexes were +2 throughout and symmetrical. Sensory exam revealed a hypoesthetic region over the C5 distribution on the right and slight hypoesthetic region over the C7 distribution on the right to pin prick and light touch. Plan: CT myelogram of the C spine. Cervical spine series including flexion and extension. Refer for pain medication management.

On July 16, 2014, CT Myelogram of the Cervical Spine, Impression: 1. Large posterior disc osteophyte complex at C4-5 effacing the ventral subarachnoid space and indenting and deforming the ventral cord contour. 2. Multilevel foraminal stenosis as described below. 3. Postsurgical changes of anterior cervical discectomy and interbody fusion at C5-6.

On August 4, 2014, the claimant presented in follow-up with continued pain rated 9-10/10. Impression: 1. Adjacent level disease. 2. Recurrent cervical radiculopathy. 3. Recurrent herniated nucleus pulposus at C4-5. 4. Cervicalgia, status post anterior cervical discectomy and fusion at C5-6 with placement of anterior cervical plate. Recommendations: 1. Anterior cervical discectomy and fusion at C4-5 with removal of hardware at C5-6, evaluation of fusion status and re-instrumentation at C4-5.

On September 25, 2014, Operative Report. Postoperative Diagnosis: 1. Adjacent level disease. 2. Cervical radiculopathy. 3. Herniated nucleus pulposus, C4-5. 4.

Status post previous anterior cervical discectomy and fusion at C5-6 with placement of anterior cervical instrumentation at C5-6. Procedures: 1. Removal of anterior cervical instrumentation at C5-6. 2. Evaluation of spinal fusion at C5-6. 3. Anterior cervical discectomy including osteophyctomy at C4-5. 4. Arthrodesis, anterior interbody technique at C4-5. 5. Application of intervertebral cage at C4-5. 6. Application of anterior cervical instrumentation at C4 and C5. 7. Bone marrow aspiration of the left anterior iliac crest. 8. Autograft for spine surgery. 9. Use of intraoperative fluoroscopy. 10. Neuromonitoring of SSEPs and motor-evoked potentials.

On October 27, 2014, CT of the Cervical Spine, Impression: 1. Worsened disk protrusion at C6-7 may impinge upon the cord to some degree. Findings are greatly improved in appearance at C4-5 with anterior plate now in place. 2. Additional finding of plate and screw defects at C6 vertebral body. 3. No convincing acute fractures.

On January 16, 2015, the claimant presented in follow-up. She was last seen on October 31, 2014 where she was prescribed Gabapentin and Baclofen. She reported worsening symptoms. Pain level was rated 10/10. Plan: Referral for psychological evaluation.

On January 20, 2015, Cervical X-rays, Impression: 1. Postsurgical change at the C4-5 and C5-6 levels. Hardware shows good position without evidence of loosening or infection. 2. Mild degenerative disc disease at C6-7.

On January 20, 2015, Cervical CT Myelogram, Impression: 1. Interval fusion of C4-5. Hardware appears to be in good position without evidence of complication. 2. Interval removal of hardware at C5-6 where there has been prior osseous fusion. 3. Moderate degenerative disc disease at C6-7 producing moderate bilateral neural foraminal narrowing and mild central canal narrowing.

On February 2, 2015, the claimant presented for follow-up. She reported neck pain with radiation into the right axilla as well as into the right side of her face with associated numbness in a nondermatomal distribution. She also felt like "something in my throat" with dysphonia and migraine headaches. Her pain level was rated 8/10. On examination her cervical ROM was restricted in lateral rotation secondary to muscle spasms. Motor exam revealed 5/5 strength throughout. Deep tendon reflexes were +2 throughout. Sensory exam revealed no hypoesthetic region to pin prick and light touch. Recommendations: Initiate a postoperative rehab program times six weeks.

On March 13, 2015, the claimant presented who recommended she continue post op PT and recommended a multi-interdisciplinary treatment approach to help overcome chronic pain, disability, depression, anxiety, PTSD and other barriers to regain function. The claimant reported her medications had been denied and she was suffering from sleep deprivation due to chronic pain, depression and anxiety. She was given a prescription for Trazodone 25 mg.

On March 24, 2015, the claimant presented for an initial physical therapy evaluation with , PT who reported the claimant demonstrated limitations with functional mobility, ambulation and safety and independence with ADL's due to pain and weakness in her upper extremities. She reported difficulty with bathing, dressing, grooming, and driving due to increase in cervical pain. She reported constant pain with daily activities and also had difficulty with grasping and holding objects. It was recommended that she would benefit from skilled PT 3 times a week for 4 weeks.

On March 24, 2015, the claimant presented also recommended physical therapy.

On March 30, 2015, UR. Rationale for Denial: For the described medical situation, Official Disability Guidelines would support consideration of treatment in the form of supervised rehabilitation services. However, based upon the records available for review, presently, medical necessity for this specific request is not established. This specific request is not presently established as specifics are not provided with regard to the amount of supervised rehabilitation services previously provided. Additionally, with respect to the cervical spine, as a general rule, aquatic therapy services would not be considered a medical necessity. Given the fact that a PEER to PEER review could not be completed, presently, medical necessity for this specific request is not established.

On April 10, 2015, the claimant presented who reported she continued to have baseline pain not controlled with current dose of Norco, insomnia and depression. Pain level was rated 7/10. Current medications: Norco, Trazadone, gabapentin, and baclofen. Plan: Start PT next week, increase Norco 7.5/325 mg. Xanax 0.5 mg for anxiety and sleep. Recommended a multidisciplinary team approach to overcome chronic pain, depression, anxiety and PTSD.

On April 28, 2015, performed a UR. Rationale for Denial: Based on the medical records submitted for review on the above referenced claimant, 6 sessions of Aquatic and Physical Therapy for the cervical spine is not recommended. Day of Injury was xx. Patient should be doing active home exercises per Official Disability Guidelines. Patient has had Physical Therapy post-surgery. There is no indication for additional Physical Therapy at this time. Current exam noted no neurologic deficits.

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

Denial of six PT and aquatics sessions for the cervical spine is Upheld/agreed on since there's lack of clinical information. There is lack of information with regards to the number of post-operative PT visits already completed, compliance with attendance, progress with range of motion/strength/function, and instruction in/compliance with a home exercise program. Therefore, the request for 6 sessions of Aquatic and Physical Therapy for the Cervical Spine is not certified at this time.

PER ODG:

ODG Physical Therapy Guidelines –

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".

Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0):

9 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0):

10 visits over 8 weeks

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

Degeneration of cervical intervertebral disc (ICD9 722.4):

10-12 visits over 8 weeks

See 722.0 for post-surgical visits

Brachia neuritis or radiculitis NOS (ICD9 723.4):

12 visits over 10 weeks

See 722.0 for post-surgical visits

Post Laminectomy Syndrome (ICD9 722.8):

10 visits over 6 weeks

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

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

Work conditioning (See also [Procedure Summary](#) entry):

10 visits over 4 weeks

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)**