

MATUTECH, INC.

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AMENDED: October 22, 2007

DATE OF REVIEW: OCTOBER 19, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI lumbar spine, lumbar myelogram and computerized tomography scan, and EMG/NCV lower extremities (08/31/07)

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

The physician providing this review is a physician, doctor of medicine. The reviewer is national board certified in physical medicine and rehabilitation. The reviewer is a member of American Academy of Physical Medicine and Rehabilitation. The reviewer has been in active practice for twenty-three years.

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 MRI lumbar spine, lumbar myelogram and computerized tomography scan, and EMG/NCV lower extremities (08/31/07).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Inc:

- Clinic notes (10/20/05 – 11/02/06)
- Procedure notes (08/17/01 – 09/06/01)
- Radiodiagnostic studies (11/30/95 – 02/06/03)
- Electrodiagnostic studies (08/11/98)
- Utilization reviews (08/31/07 – 09/27/07)

M.D.:

- Clinic notes (04/20/07 – 09/13/07)
- Radiodiagnostic studies (04/27/07)
- Electrodiagnostic studies (06/14/07)

The ODG guidelines cited in the utilization reviews

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a patient who injured his lower back when he tripped over a welding lead. He had the onset of substantial pain in his lower back radiating down his left leg.

M.D., noted the patient had been treated with conservative therapy but due to continued significant pain, he was eventually taken to surgery in August 1995 with fairly good results. Dr. prescribed medications and initiated physical therapy (PT). The patient later fell off a porch injuring his left shoulder and knee. Magnetic resonance imaging (MRI) of the cervical spine demonstrated disc protrusion at C5-C6 and slight narrowing at C6-C7. In 1997, Dr. noted the patient was status post cervical laminectomy performed on February 21, 1997. The patient continued to have a mild postlumbar laminectomy syndrome. On July 24, 1997, Dr. assessed statutory maximum medical improvement (MMI) and assigned 18% whole person impairment (WPI) rating. For continued back pain, Dr. started Neurontin and hydrocodone and recommended a program of stabilization exercises. The patient underwent lumbar epidural steroid injections (ESIs).

Electromyography (EMG) study of the lower extremities was normal. In 2001, Dr. administered a series of two L5-S1 ESIs. Computerized tomography (CT) of the lumbar spine showed: (a) Status post left L5 laminectomy with what appeared to be recurrent disc herniation causing impingement against the left S1 nerve root with a possible scar formation in the left posterolateral aspect of the posterior L5-S1 margin; (b) diffuse spondylotic bulges identified at L3-L4 and L4-L5 with minimal bilateral L4 nerve root impingement at L3-L4 caused by the disc bulge; and (c) facet joint osteophyte formation at L3-L4, L4-L5, and L5-S1 causing mild bilateral lateral recess stenosis.

In 2006, M.D., treated the patient with ibuprofen, acetaminophen, Naprosyn, Flexeril, Indocin, and cold packs. MRI of the lumbar spine had shown discogenic sclerosis and foraminal narrowing at L3-L4 and L5-S1.

In April 2007, M.D., evaluated the patient and noted history of a back, lumbar laminectomy, and a cervical laminectomy in 1997. Dr. diagnosed degenerative disc disease (DDD) and neuropathy and prescribed Neurontin, Mobic, and Lortab. MRI of the cervical spine showed mild degenerative changes at C4-C5 and C6-C7 with stenosis of the nerve root foramina at C6-C7. MRI of the thoracic spine showed mild DDD from T4 through T10. Lumbar MRI demonstrated: (a) DDD mainly from L3 through S1 with scar tissue seen along the anterior thecal sac in the right paracentral region; and (b) bulging discs and facet degenerative change contributing to mild-to-moderate stenosis of the nerve root foramina from L3 through S1.

M.D., noted that EMG/NCV of the lower extremities was within normal limits. In August and September, Dr. stopped the Lortab and started a trial of Avinza and Norco, Medrol Dosepak, Opana ER, and Lidoderm patches.

On August 31, 2007, request for lumbar MRI, lumbar myelogram, and EMG/NCV of the bilateral lower extremities was denied. The rationale: *The patient had a history of prior surgery to the lumbar region, and had persistent pain with*

radiation to the lower extremities. However, the current request comes with limited clinical information that does not explain the identity or specialty of the proposed referral physician nor is supporting information provided.

On September 27, 2007, the appeal for the previously requested diagnostic studies was denied. The rationale: *In close review of the medical records, this claimant was being managed on multiple narcotics at relatively high doses of levels. There is no report of any intervening injuries. Multiple diagnostics had been performed in 2006 and 2007 the sequence of which does not imply that claimant has had any severe deterioration. Since two neurosurgeons had opined that further back surgery was not in this claimant's best interests, and all three diagnostics requested have been performed within the last six months, for a claim, it is unclear the medical necessity to repeat these studies without specific information which would lead to surgical opinion, based on a physical exam and history, which surgery would be indicated, and at which point updated studies would be helpful. It appears that the claimant's subjective complaints which were reported to be worsening correlate to the cascading narcotic dosing. Given this patient's history of alcoholism and incarceration of unknown events, clinical information was needed to confirm that the claimant was indeed consuming the volume or narcotic prescribed (100 Lortab per month).*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. PATIENT UNDERWENT SAME OR SIMILAR STUDIES LESS THAN SIX MONTHS PRIOR TO THIS REQUEST WITHOUT ANY EVIDENCE OF SIGNIFICANT CHANGE; IN FACT, THE EMG WAS REPORTED AS UNREMARKABLE. GUIDELINES SPECIFICALLY STATE GREATER THAN ONE YEAR UNLESS THERE IS OBJECTIVE DETERIORATION, AND BASED ON THE RECORDS AVAILABLE, THERE IS NO REPORTED DETERIORATION ONLY CHRONIC ONGOING PAIN. THERE IS NO EVIDENCE TO SUPPORT THE NEED OF REPEATING DIAGNOSTIC TESTS PERFORMED ONLY SIX MONTHS PRIOR TO THE REQUEST.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

KAMURA ELECTRODIAGNOSTICS IN DISEASE OF NERVE AND MUSCLE