



DATE OF REVIEW: April 9, 2008

IRO Case #:

Description of the services in dispute:

1–2 office visits per year and the oral medications Klonopin 1 mg, Neurontin 300 mg, and Darvocet–N100.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Physical Medicine & Rehabilitation in General Physical Medicine & Rehabilitation and Pain Medicine. This reviewer has been in active practice since 2005.

Review Outcome

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

Upheld – Medical necessity is not established for 1–2 office visits per year and the oral medications Klonopin 1 mg, Neurontin 300 mg, and Darvocet–N100.

Information provided to the IRO for review

1. Utilization review determination dated 12/05/07
2. Utilization review determination dated 02/11/08
3. Employer's first report of injury or illness
4. Medical records Dr.
5. EMG/NCV study dated 09/27/1999
6. Medical records Dr.
7. Physical therapy records
8. Functional capacity evaluations
9. Evaluation Dr. dated 02/24/00
10. DWC form 93 report of medical evaluations
11. Laboratory reports
12. Report of lumbar discography dated 09/21/00
13. Designated doctor examination dated 02/16/01
14. Medical records Dr.

15. Medical records Dr.
16. Peer review Dr. dated 10/27/06
17. PRME Dr.
18. MRI of the lumbar spine dated 08/20/1999
19. CT of the lumbar spine dated 09/29/00
20. Laboratory reports

Patient clinical history [summary]

The patient is a xx year old male who is reported to have sustained an injury to his low back on xx/xx/xx. The first report of injury indicates that the patient pulled a pallet jack from underneath a pallet and felt pain in his low back. The patient was evaluated by Dr. on xx/xx/xx.

The patient is reported to have been working as a night stocker at xxxx and was working and had a fork get caught underneath the pallet. He jerked on it and felt pain in his left posterior hip. There is little more than soreness that he would experience from just normal use but he continued to work. He had to do some lifting and he noticed his posterior hip and low back were sore. He worked his entire shift. The following day he found significant pain on trying to bear weight. He reported pain all the way down to the foot with some numbness in the third and fourth toes of the left foot.

The patient was seen at xxxx medical center and was admitted by Dr.. He reports that he has not had any problems with his back other than it gets sore when he works hard. The patient reports being a little bit better. He still cannot get out of bed without recreating severe spasm. Coughing and sneezing increases his pain. When he tries to get up his leg pain is markedly increased. At this time the patient is evaluated lying in bed. He basically has no back tenderness, no tenderness over the sacroiliac joints. He has some slight sciatic notch tenderness on the left side, some posterior thigh and posterior knee tenderness. He cannot sit up so straight leg raising is not tested. Supine straight leg raising is negative on the right at 90 degrees and markedly positive on the left at 30 degrees in the posterior hip and posterior left thigh with a positive popliteal compression test on the left side. Annulus torsion test is negative bilaterally. Neurologic examination reveals intact sensation to light touch in the lower extremities. Deep tendon reflexes are trace to 1+ in the patella and Achilles bilaterally. The left calf muscle is somewhat irritable. Strength is graded as 5/5 except for the anterior tibialis on the left side which is slightly weak. X-rays show a spondylolysis without spondylolisthesis. The patient was diagnosed with acute severe left sciatica, bilateral spondylolysis, acute lumbar spasm, and rule out herniated disc.

An MRI of the lumbar spine dated 08/20/1999. This study reports degenerative disc changes as described which appear to be most severe at L3-4 to the left of midline. There is some impingement upon the left side of the thecal sac and the L4 nerve root at this level. Findings suggestive of spondylolysis with very mild spondylolisthesis at L5-S1.

The patient was seen by Dr. on 08/23/1999. Dr. reports an MRI of the lumbar spine showed diffuse

arthritic changes of the lumbar spine at L1–2 with some disc space narrowing at the same area. There were no focal point herniations at that level. At L2–3 there were degenerative changes with a mild diffuse disc bulge. At L3–4 there was posterior bulging and it appears to have some mild but generalized canal narrowing. There is no evidence of disc herniation at L4–5. At L5–S1 there is spondylolysis with a minimal grade I spondylolisthesis noted. The patient was referred for electrodiagnostic studies on 09/27/1999. These studies are reported to be consistent with a left L4 radiculopathy. The patient underwent a selective nerve root block at L4 on 10/26/1999. Postoperatively he was reported to have 50% relief of his pain. Additional records indicate facet blocks were done at L3 on the right side on 02/09/00 with 85% relief of his pain.

On 02/24/00 the patient was seen by Dr. for independent medical examination. Dr. opines that the patient is not at maximum medical improvement and recommends that the patient needs to be engaged in aggressive physical therapy. The patient is reported to have undergone facet blocks at L3 on the right side on 02/09/00 and has 80% relief of his pain except for stabbing pain occasionally. He is further reported to have a selective nerve root block done on the L4 root on 10/26/1999 and the patient is improved. His pain is reported to be 90% left low back and 10% left leg. The patient appears to have been referred for a work conditioning program which is reported to have been completed on 05/17/00. The patient subsequently underwent discography on 09/21/00. This study reports discogenic pain at L2, L3 and L4. The patient was subsequently evaluated by Dr. on 01/10/01. Dr. finds the patient to be at clinical maximum medical improvement and finds the patient to have a 13% whole person impairment.

A CT of the lumbar spine was performed on 09/21/00. This study reports disc bulges and degenerative changes. At L2–3 there is a circumferential disc bulge with osteophyte formation. There is moderate right inferior neural foraminal narrowing, left inferior neural foramina appears to be patent. There is moderate spinal stenosis, a right posterior paracentral disc protrusion with associated contrast material. At L3–4 there is a circumferential disc bulge and osteophyte formation with moderately severe spinal stenosis. Dorsal central likely osteophyte formation is identified. There is moderately severe spinal stenosis, moderately severe bilateral inferior neural foraminal narrowing seen with moderate bilateral facet hypertrophy and ligamentum flavum hypertrophy. At L4–5 there is extravasation of contrast material into the left posterior paracentral aspect of the disc seen consistent with an annulus rupture. There is mild spinal canal stenosis, mild bilateral facet hypertrophy. There is mild left inferior and moderate right inferior neural foraminal narrowing. At L5–S1 contrast material appears essentially contained within the central portion of the disc. The spinal canal and neural foramina appear essentially patent. Bilateral facet hypertrophy is seen.

The patient was subsequently evaluated by Dr. on 02/16/01. Dr. functioning as a designated doctor finds the patient to be at clinical maximum medical improvement and assesses a 13% whole person impairment. Records indicate that the patient was followed by Dr. and subsequently came under the care of Dr. DWC form 73 indicates that the patient was seen by Dr. between 09/16/02 through 05/30/06. No clinical records were submitted.

The patient initially came under the care of Dr. . At this time the patient reports continued low back pain. He has been treated with physical therapy and oral medications. He reports having 6 herniated discs. The patient has been back at work on restricted duty and works 4 hours per day. On physical examination he is well developed. He is able to go from a sit to stand independently. He has decreased range of motion of the lumbar spine in all planes. He has good strength in all the major muscle groups. He has no leg length discrepancy. He has no swelling in his legs. He has good sensation. Straight leg raising is negative and only caused back pain. Records indicate that the patient followed up with Dr. on a frequent basis.

On 10/27/06 the record underwent peer review by Dr.. Dr. notes the history above. Dr. notes that the patient initially presented with symptoms of left sided radiculopathy; however, from the documentation reviewed there did not appear to be any specific nerve root compression on imaging studies. However, he complained of left sided pain and it was reported that electrodiagnostics were compatible with such. Dr. opines that the claimant sustained a soft tissue injury with temporary exacerbation of the underlying DDD. It is reported that his pain is primarily right sided and in all medical probability his current symptomatology is not related to the xx/xx/xx event but rather to his multilevel degenerative disc disease.

On 02/14/06 the patient was seen in follow up by Dr. He has increasing discomfort in his back. He reports trouble raising his right leg and foot. He describes tingling and burning in the right foot. On examination his calf circumference is 39 cm bilaterally. He can go from sit to stand independently. He uses a cane for ambulation assistance. Lumbar range of motion is reduced. He has increased pain with weightbearing on the right leg. He has increased pain with resisted hip abduction and decreased pain with hip adduction. He is tender over the right SI joint. He is also tender in the right lumbar paraspinal muscles. There is spasm of the right lumbar paraspinal muscles. Calf circumference is symmetric. Straight leg raising is negative. The patient was continued on oral medications and the next most recent physical examination is dated 05/30/06. Again the patient's calf circumference is 39 cm bilaterally. He can sit and stand independently. He can go up on his toes and heels. Straight leg raising produces some discomfort in his right thigh. He has pain in the right buttock. He is tender in the right SI joint. He does not have any muscle spasm. Lumbar flexion is reduced. His gait pattern is reciprocal.

A peer review was performed by Dr. on 05/17/07. Dr. opines that a request for one office visit in a 3 month period and the medications Klonopin, Neurontin and Darvocet with Nexium are not medically necessary.

Dr. has subsequently requested that the patient receive office visits one to two times per year and continue receiving the medications Klonopin 1 mg, Neurontin 300 mg and Darvocet N100 for pain. On 12/05/07 Dr. found that these requests were not medically necessary. Her rationale is not included. On 02/11/08 Dr. issued an adverse determination. Dr. reports that the patient appears to have a chronic subjective low back pain. There are no signs of radiculopathy on physical exam.

He reports ODG would not support chronic benzodiazepines or opioids for chronic nonspecific low back pain. He again reports there are no signs of radiculopathy necessitating the need for Neurontin. He reports that since Klonopin, Neurontin and Darvocet are not medically necessary and their use is not supported by ODG, office visits so those medications can be prescribed are also not considered medically necessary. A peer to peer contact was made with Dr. He advised Dr. that he did not feel that the patient needed the above mentioned medications at this time. Dr. recommendation of non-certification was unchanged.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The reviewer concurs with the two previous reviewers. Current evidenced based guidelines do not support the chronic use of these medications. The patient has a history of lumbar radiculopathy which appears resolved. The most current examinations are from last year and do not support the presence of an active radiculopathy necessitating the continued use of these medications. Further follow-up visits would not be considered appropriate given that medical necessity for continued use of oral medications has not been established.

A description and the source of the screening criteria or other clinical basis used to make the decision:

The Official Disability Guidelines, 11th edition, The Work Loss Data Institute.

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