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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right caudal ESI (62319)

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:

Overtuned (Disagree)

Medical documentation supports the medical necessity of Right caudal ESI (62319)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Texas Department of Insurance:

- Utilization Reviews (03/11/08 and 03/26/08)

Attorneys at Law:

- Hospitalization (02/25/07 – 03/03/07)
- Radiodiagnostics (02/25/07 – 08/22/07)
- Office notes (03/12/07 - 04/01/08)
- Procedure notes (02/26/07 – 10/23/07)
- Utilization Reviews (03/11/08 and 03/26/08)

Pain Consultants, Dr. :

- Radiodiagnostics (02/25/07 – 04/11/07)
- Office notes (05/05/07 - 04/01/08)
- Procedure notes (10/23/07)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old male who fell 15-20 feet off a mud tank at an oil rig. He landed on his feet and then fell on his back injuring his mid back and lower back region.

Following the injury, the patient was taken to Medical Center and underwent radiodiagnostic workup, which revealed compression fracture at L1 with retropulsion of the posterior aspect of L1 in relationship to T12 and L2, and old healed fracture with hypertrophic bone inferior superior pubic rami on the right with suspicion of acute nondisplaced fracture. The same day, the patient was transferred to Hospital, where he underwent extensive radiodiagnostic workups. X-rays of the pelvis revealed well corticated deformity at the right superior and inferior pubic ramus suggesting remote trauma. X-rays of the chest, computerized tomography (CT) of the head and cervical spine were all negative. CT of the thoracic spine revealed burst fracture of L1 with associated retropulsion of fracture fragment with at least 50% spinal canal stenosis and approximately 60% disc height loss, and healed right inferior and superior pubic rami fractures. Magnetic resonance imaging (MRI) and CT scan of the lumbar spine revealed acute anterior wedge compression fracture of L1 with greater than 50% compromise of the bony spinal canal and right paracentral disc herniations at L3-L4 and L4-L5, which were felt to be acute.

On February 26, 2007, , M.D., an orthopedist, performed corpectomy of the L1 vertebral body with decompression of spinal canal and anterior interbody arthrodesis from T12 through L2. Postoperatively, a left-sided chest tube was placed. X-rays revealed hazy opacity at the right apex and right base likely due to pleural fluid, in addition to sub-segmental atelectasis at the right base. Follow-up x-rays showed clear lung fields with only minimal residual interstitial markings with tiny left apical pneumothorax and therefore chest tube was removed. On March 3, 2007, the patient was discharged in a stable condition with prescriptions for Vicodin, Flexeril, and lorazepam.

The patient continued seeing Dr. and reported considerable low back pain, burning in his feet, left worse than right, and symptoms of depression and emotional lability. He was referred to a pain management physician and was suggested to undergo psychological counseling for his depression.

In May 2007, the patient was evaluated by, M.D., a pain management physician. He reported no improvement with the surgery and had left foot numbness, tingling, and low back pain radiating to the right hip region. He was utilizing a cash brace and hydrocodone for his pain. Dr. added Robaxin, Lyrica, Norco, Fentanyl patches, and Effexor.

On October 23, 2007, Dr. performed right L1 through S1 facet joint injections and right sacroiliac (SI) joint block for lumbar facet arthropathy and sacroilitis. Post injection, the patient reported 50% improvement for about three weeks and

therefore Dr. recommended radiofrequency thermocoagulation of the lumbosacral spine.

On February 21, 2008, the patient returned to Dr. and it was reported that request for RFTC was denied. He continued to have severe low back pain and the pain had significantly limited his activities. On examination, there was limited lumbosacral range of motion (ROM) and pain with flexion and extension; tenderness over the lumbosacral spine and paraspinal muscles especially on the right and over the right SI joint; and positive seated SLR test on the right. Dr. prescribed Duragesic patch and refilled Robaxin and Lyrica. She reviewed MRI of the lumbar spine performed in 2007, which showed right paracentral disc herniations at L3-L4 and L4-L5, thought to be acute. She recommended epidural steroid injection (ESI) that would help the pain coming from these disc herniations.

On March 11, 2008, the request for the lumbar ESI was denied by, M.D. Rationale: *There was insufficient findings on lumbar spine MRI and clinical exam findings to warrant treatment with a caudal ESI.*

On March 13, 2008, Dr. reported that the pain was most likely a combination of facet-related and discogenic pain as well as due to right paracentral disc protrusions at L3-L4, L4-L5, and L5-S1. She increased the dose of Duragesic patch, prescribed Restoril, and recommended an ESI.

On March 26, 2008, reconsideration request for the caudal ESI was denied by, M.D. Rationale: *The clinician has reported on physical examination that the claimant has normal motor, sensory, and reflex examination, which would dispute the presence of radiculopathy. ODG requires the objective evidence of radiculopathy for ESIs.*

On April 1, 2008, the patient underwent a psychological diagnostic interview with, Psy.D. He continued to have severe pain in his low back radiating to his right leg to his knee with numbness to his toes. Dr. recommended individual psychotherapy for his depression and anxiety.

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

BASED ON THE RECORDS IT APPEARS THE ODG RECOMMENDATIONS WERE MET AS THE MRI IS CONSISTENT WITH POSSIBLE RADICULOPATHY AND THE PATIENT HAD A POSITIVE STRAIGHT LEG RAISE. GIVEN THE PATOLOGY AT L5, A CAUDAL ESI IS REASONABLE.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**