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Notice of Independent Review Decision

DATE OF REVIEW: January 16, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy, 3 times a week for 2 weeks (6 visits). Therapeutic exercises (97110), electrical stimulation (G0283), and massage (97124)

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

The physician providing this review is a Doctor of Chiropractic. The reviewer is certified by the National Board of Chiropractic Examiners and Texas Board of Chiropractic Examiners. The reviewer has been in active practice for 22 years.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient is a xx-year-old male who was injured on xx/xx/xx, when he was lifting boxes off the dock and injured his back.

1998 – 2000: Initially the patient received physical therapy (PT) and medications for low back pain. He had prior injury to his low back in xxxxx and never had complete resolution of low back and left leg pain from that injury. Electromyography/nerve conduction velocity (EMG/NCV) study suggested left L5 radiculopathy. Magnetic resonance imaging (MRI) revealed worsening of the annular bulging and posterior spondylosis at L5-S1 since xxxxxxparticularly in the right paracentral and right foraminal location with possible mild- to-moderate degree of extrinsic impression upon the emanating right L5 nerve, and Modic type I fibrovascular marrow endplate change persistent at L5-S1. Lumbar myelogram revealed relative peripheral underfilling of the bilateral L5 nerve root sleeves, and marked intervertebral disc degeneration at L5-S1 with mild retrolisthesis of L5 on S1. He underwent a lumbar epidural steroid injection (ESI) and individual psychotherapy sessions and received multiple medications. MRI of the lumbar

spine revealed marked intervertebral disc degeneration at the L5-S1 level which had progressed significantly when compared to the previous MRI. The degree of bilateral foraminal stenosis contacting with the S1 nerve root had not changed significantly. His treating physician placed him at maximum medical improvement as of June 11, 2000, and assigned 24% whole person impairment (WPI) rating. On August 17, 2000, performed bilateral hemilaminectomy and discectomy at L5-S1. The patient attended PT and received medications.

2001 – 2003: MRI of the lumbar spine revealed: 1). Marked degenerative changes at the L5-S1 levels, mild grade I subluxation of L5 on S1 with pseudobulge of the disc, bilateral foraminal stenosis at L5-S1; 2). At L4-L5, a very tiny central protrusion of the disc into the spinal canal mildly impinging the sac, the disc protruded into the floor of both neural foramina; however, it did not appear to be impinging the nerve root, and ligamentum flavum hypertrophy and mild facet hypertrophy at this level; 3). At L3-L4, a mild right lateral disc protrusion of the disc into the spinal canal and into the right neural foramen, mildly impinging the sac but did not appear to impinge the exiting nerve root; 4). Mild facet hypertrophy at L1-L2, L2-L3 and L3-L4 with the thecal sac mildly angulated at these levels indicative of mild central spinal stenosis. The patient was treated with pain and sleep medications and muscle relaxants. He attended 30 sessions of chronic pain management program (CPMP) which was somewhat helpful. He reported he had worsening of his complaints after the surgery.

A peer reviewer opined that ongoing complaints were related to the original injury; diagnostics, surgery, pain management, and pain medications were appropriate; no further treatment was necessary; and he should be weaned off narcotics and maintained on antidepressants and NSAIDs. Another peer reviewer opined that the psychiatric condition was not related to the

compensable injury and psychiatric treatment and medications were not reasonable and related to the compensable injury.

2004 – 2005: MRI of the lumbar spine revealed minimal disc bulge at L4-L5 and DDD at L5-S1 with a small central disc protrusion. , M.D., a designated doctor, opined that the patient could return to work. In a functional capacity evaluation (FCE), the patient qualified at medium physical demand level (PDL). EMG/NCV study revealed mild residual chronic lower lumbosacral radiculopathy around L5 on the right and mild sensory peroneal neuropathy bilaterally. A lumbar discogram was positive for concordant pain at L4-L5. CT revealed right paracentral and lateral posterior contrast leak at L4-L5 consistent with annular tear. There was right paracentral and right lateral 3-4 mm disc protrusion along with bilateral hypertrophic facet changes creating mild right-sided stenosis as well as early right-sided foraminal narrowing.

The patient was maintained on medications including Kadian, Ambien, Norco, Valium, Soma, and Flexeril. A surgeon recommended an intradiscal electrothermal (IDET) therapy whereas another recommended posterior lumbar fusion.

A peer reviewer opined that review of records failed to establish existence of any damage or harm to the physical structure, current medications were not reasonable and necessary to the injury, no treatment other than interdisciplinary program of functional restoration and detoxification would be reasonable, and effects of the injury had resolved.

MRI of the lumbar spine revealed: 1). Marked narrowing of the L5-S1 disc space, diminished L5-S1 disc signal, and a prominent bony osteophyte arising from the posterior inferior corner of the L5 vertebral body. 2). A broad base 2 mm disc protrusion at L4-L5 in the midline extending towards the opening of both neural foramina, and the disc protrusion producing a mild narrowing of the central canal. 3). At L2-L3, a 3 mm broad disc protrusion of disc material in the midline extending towards both neural foramina and disc protrusion producing a mild amount of narrowing of the central canal, but not affecting the neural foramina.

, M.D., a designated doctor, assessed statutory MMI as of July 2, 2000, and assigned 5% WPI rating. However, another designated doctor, , M.D., deferred MMI due to pending surgery.

The patient attended individual psychotherapy sessions. In a required medical examination (RME), M.D., opined that no further diagnostic testings were necessary, majority of patient's problems were psychiatric, he should be under the care of a psychiatrist, ongoing treatment not reasonable and necessary, he was not a candidate for surgery, and his prognosis was extremely poor.

2006-2007: A one level fusion surgery planned in January could not be performed as the patient suffered a cardiac arrest on the table during catheterization, but was rescheduled for surgery. He was provided with lumbar corset. Dr performed RME and opined that the patient had failed back syndrome complicated by excessive psychological overlay abnormality. The second surgery would have an extremely poor outcome and the treatment would

be on maintenance follow-up only. Effexor was appropriate while Ambien and Valium were not.

The patient underwent a psychological evaluation and was diagnosed with psychosocial factor mood disorder and generalized pain disorder secondary to chronic pain. Functional restoration program including a chronic pain management (CPMP) was recommended. Duragesic patches, oxycodone, Restoril, Lexapro, Lyrica, and Elavil were added.

In a peer review, , M.D., opined as follows: There had been documentation of psychological overlay indicating abnormal illness behavior with chronic acquired pain. Ongoing symptomatology was related to the injury. There was no information indicating pre-existing condition including the trauma. The patient had failed back surgery syndrome as well as abnormal illness behavior. A pain management program might be appropriate with an emphasis on weaning off opiates. The patient was not a reasonable candidate for intrathecal morphine pump or spinal cord stimulation. Pain medications would be reasonable including Duragesic patches, Narco, and Elavil; whereas, Oxycodone, Ultram, and Restoril should be weaned off.

In September 2007, , M.D. assessed lumbosacral radiculopathy without myelopathy and stated that the patient had not yet reached statutory MMI and was referred to a neurosurgeon.

In a peer review, Dr. opined that the patient should be on self monitor home exercise program alone and the ODG would not support any other intervention such as medical equipment, modalities, passive treatments, and supervised chiropractic therapy. The reasonable medications could include Ultram and hydrocodone.

2008: Neurosurgeon , M.D. noted right leg weakness. The motor function showed that the patient had give way weakness in lower extremities and that straight leg raise (SLR) was positive for back pain. He reviewed the MRI and noted there was decreased disc space at L5-S1 with a small disc at L4-L5 and recommended further diagnostic studies.

In April, Dr. performed a repeat RME and rendered the following opinions: The patient's ongoing status was a failed back syndrome complicated by excessive psychological overlay. Interventions like intrathecal pump and spinal cord stimulator would not be appropriate. Treatment should be maintenance follow-up only. There was no indication for further diagnostics, DME, chiropractic therapy, PT, work hardening, or any referrals.

On May 30, 2008, Dr. performed lumbar laminectomy L5, inferior aspect of L4 bilaterally, and decompression of L4-L5 and L5-S1 bilaterally. Subsequently, the patient was asked to wear a lumbar brace and follow-up with Dr. for physical therapy.

From June through October, the patient attended 28 sessions of PT consisting of massage, electrical muscle stimulation, ice application, ultrasound, myofascial release, traction, and was provided with a home electrical muscle stimulator unit, and a conductive garment.

In September 2008, medications continued were Narco, Soma, diazepam, tramadol, and Valium. The patient developed new problem of numbness in both large toes, and postoperatively developed insomnia and dyssomnia.

On November 12, 2008, the patient was seen by , D.C. Since stopping the therapy, he reported increased pain in his lower back. He reported that about three weeks prior, he had onset of severe pain. Dr. noted the patient was using a cane for ambulation. Examination showed positive SLR on the right with tenderness and spasms of the bilateral erector spinae, bilateral gluteus maximus, and bilateral piriformis, and increased pain with range of motion. She recommended participating in chiropractic rehabilitation therapy consisting of heat, electrical stimulation, traction, and exercises three times a week for two weeks.

On November 19, 2008, the request for PT was denied by , D.C. with the following rationale, *“Last postoperative PT was on October 1, 2008. The patient felt well enough to talk about returning to work four hours per day. This was flare up that happened two weeks ago. He had been feeling better, now flared up. The patient’s progress was discussed with Dr. at the end of the postoperative course, as well as his motivation to return to work”. The current request exceeded guidelines for prospective review. This patient can continue with a home exercise program.*

On December 4, 2008, , D.C., turned down the first appeal reconsideration with the following rationale, *“The patient injured the low back on xx/xx/xx, and was ten and half years post soft tissue injury. He had already completed 28 plus postop PT visits since the lumbar surgery was performed. Since stopping therapy, the patient had an increase in pain in his low back, but no mechanism or date of onset has been provided for the increase in pain which took place at the end of October. This episode in the low back or flare-up has been over one month ago and majority of flare ups in low black would resolve with or without treatment within a five to six weeks time frame. The patient had already exceeded the ODG PT guidelines. The ODG does not support the passive therapies requested especially this long after the date of injury or surgery. The patient has already had sufficient supervised therapy to continue with a home exercise program. Based on the clinical information submitted and the evidence based, peer reviewed guidelines the request for additional PT was non-certified.*

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

The injury was on xx/xx/xx. As of 02/13/2003, it was clear that the claimant had received more than reasonable trials of care without therapeutic benefit. There was a synopsis and opinion rendered by MD on 06/23/04 that provided an excellent overview of the errors made in this case. Despite all the reasons NOT to proceed with further invasive interventions another surgery was sought. On 04/03/08, , MD reported that further diagnostics or surgery was not appropriate and that medication management was the only treatment that should be considered. Despite the many reports and evaluations to the contrary, I, MD provided laminectomy on 05/30/08. The claimant had post surgical physical therapy provided by , DC. The claimant completed the course of post surgical

physical therapy and more was requested. There was no objective evidence in the voluminous file of 1000 plus pages of any therapeutic benefit from the extensive intensive and invasive course of treatment provided. He continues to use the cane, constantly complains of severe pain as he has for several years, and remains off work as he has for several years. There is no support in the records for further chiropractic/physical therapy based on ODG web-based treatment guidelines. The treatment program has exceeded the parameters of care without significant therapeutic benefit.

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**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**