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Notice of Independent Review Decision

DATE OF REVIEW: June 10, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar myelogram with post myelogram CT

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 is in active practice in the state of Texas. The reviewer has been in active practice for 25 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

TDI

- Utilization reviews (04/21/09, 05/18/09)
- Reviews (02/20/09)
- Office visits (04/13/07, 04/06/09, 04/23/09)
- Diagnostics (08/20/08)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was injured on xx/xx/xx. She developed low back pain while arising from a bent over and squatting position.

2007: On April 13, 2007, M.D., performed a peer review and noted the following history:

2002: The patient had a back surgery on the right to include L4-L5 compression on May 2, 2002. She had persistent pain, and a lumbar magnetic resonance imaging (MRI) on June 16, 2002, demonstrated epidural fibrosis on the right at L4-L5 with slight bulge, right more than left. The patient had a repeat L4-L5 discectomy for recurrent disc herniation on August 21, 2002, by Dr. Postoperatively, she continued to have back and right lower extremity pain. Attempted discography on November 22, 2002, was not tolerated.

2003: The patient was seen in consultation by Dr. a neurologist, on January 2, 2003, who did not recommend surgery. There was concern about the fact that the patient had depression related to a home situation. A lumbar MRI on March 12, 2003, demonstrated postoperative changes with a scar on the right at L4-L5 and mild facet disease at L5-S1. The patient had another operation by Dr. on April 29, 2003, consisting of posterior lumbar interbody fusion at L4-L5. Dr. declared the patient at maximum medical improvement (MMI) with 10% whole person impairment (WPI) rating on August 22, 2003. The patient entered into a chronic pain management program (CPMP) under the direction of Dr. and Dr. , and chiropractor .

2004: A lumbar CT/myelogram on July 18, 2004, demonstrated fairly solid fusion at L4-L5 with left foraminal protrusion, and 4 mm at L3-L4 without nerve root deformity. Her pain level continued at 6/10 in the pain management program.

2005: On January 3, 2005, Dr. noted low back pain with intermittent radiation to the lower extremities, with numbness, tingling, and weakness. The pain was aggravated by sitting, standing, and walking. Physical examination revealed diminished lumbar range of motion (ROM), equal deep tendon reflexes and a non-antalgic gait. The patient also had a history of a prior C3-C4 fusion. There was diminished sensation at L5-S1, and straight leg raise (SLR) causing leg pain. Dr. Nguyen diagnosed lumbar radiculopathy and lumbar facet syndrome. The patient also had a cardiac stent on December 3, 2004.

2006: The patient was followed by pain management specialist, with the last treatment note from October 22, 2006, approximately six months ago. She had pain level of 6/10. Examination revealed tenderness on L2 through S1 with moderate spasm. Gait was not antalgic, and lumbar ROM was limited in flexion, extension, and lateral bending. DTRs were symmetrically decreased, with decreased sensation along the L5-S1 dermatome with pinprick, and SLR with shooting pain down the bilateral legs. The diagnosis was lumbar radiculopathy, lumbar facet syndrome, and insomnia secondary to chronic pain. Treatment recommendation included continuing Norco, trazodone, Zanaflex, and Lyrica.

Dr. gave the following opinions: (1) The patient had mild pre-existing lumbar facet disease. Her diagnosis was failed back surgery syndrome with residual back and neuropathic lower extremity pain. (2) Details of the injury were not available, as the injury occurred on xx/xx/xx, and the medical records did not start until July of 2002. Simply stated, the patient had three spine surgeries in causal relationship to the work injury of xx/xx/xx. As such, the patient's current condition of failed back surgery syndrome with chronic pain syndrome was causally and directly related to the work injury of xx/xx/xx. (3) The patient may need to be managed by a pain management specialist indefinitely. As of the most recent medical record, the patient was taking Norco 10/325 mg. (one three times a day). Given her chronic back and neuropathic pain, this was not unreasonable. Zanaflex was a centrally-acting muscle relaxant which should not be taken on a maintenance basis, but should only be taken on an as needed basis. Trazodone was for sleep and was reasonable as pain frequently caused sleep deprivation. Lyrica was also reasonable. No over-the-counter

substitutions should be considered. (4) On a go-forward basis, there was no indication for additional physical therapy (PT), durable medical treatment (DMT), additional diagnostic testing, or further surgery. Pain management was appropriate.

2008: MRI of the lumbar spine revealed: (1) Posterior bulges at L1-L2, L2-L3, and L3-L4 with mild foraminal encroachment, mostly the left L3-L4. (2) Previous laminectomy and posterior fusion with pedicle screws and disc prosthesis at L4-L5 and probable foraminal narrowing. (3) Probable right foraminal narrowing at L5-S1. (4) Posterior bulge at T9-T10.

On December 1, 2008, the patient underwent caudal epidural steroid injection (ESI).

2009: On February 20, 2009, M.D., performed a medical evaluation and noted that the patient had a long and complicated history. *Initially, the patient had noticed sudden pain in the lower back with radiation down the back of the right hip all the way down to the right foot. This was associated with numbness and tingling along with weakness in the right leg. The patient had undergone ESI and PT but none of them had given a significant degree of relief. She then underwent three surgeries but did not get much relief from this operation and was referred to Dr. a pain management physician, who treated her for chronic pain syndrome and failed back surgery syndrome. She also had several ESIs and was receiving medications prescribed by Dr. She had endogenous depression and had received electroshock treatments for this on several occasions. She saw Dr. on a monthly basis who was refilling her medications which included oxycodone, trazodone, gabapentin, and Zanaflex. She also utilized Zolpidem at night and hydrocodone for breakthrough pain. She had not been able to decrease these medications because the pain had not diminished. She was unable to walk without the use of a walker and could walk approximately 50 feet. She could sit for approximately 20 minutes and get up and move to change positions. She could stand only five minutes and could not climb stairs or bend her back at all. The right leg was much worse than the left. The pain became progressive and more severe during the past four years. She recently underwent another series of electroshock treatment because of her endogenous depression. She continued to see a pain management physician on a monthly basis. Imaging studies reported evidence of spinal fusion with pedicle screws and fusion rods at the level of L4-L5. She also had evidence of degenerative disc disease (DDD) at L3-L4 above the fusion at the level of L4-L5.* Dr. opined: (1) The problem that the patient was having with her back was related to the original injury and the three failed back surgeries that she had gone through. None of the above conditions except the lower back problems were related to the compensable injury. (2) She had still not recovered from the original injury and the three failed back surgery procedures. (3) Her depression appeared to be endogenous depression and did not appear to be part of her compensable injury. (4) All the medications that she was taking appeared to be necessary. She had apparently not been abusive on these medications. (5) No weaning was needed on any of these medications. (6) The records did not support the need for continuing chiropractic treatment in this case. The only thing that would warrant consideration was a lateral column stimulator trial provided this would not interfere with subsequent electroshock treatments which she might need to have. (7) She needed to continue monthly visits to her pain management physician for

re-evaluation and prescriptions refills. (8) It was doubtful if future surgery would benefit her.

On April 6, 2009, D.C., noted the patient was having weakness in her leg and was still continuing to utilize a walker. She continued to be maintained on pain medications, which seemed to help her temporarily. Examination revealed lumbar paraspinal spasm, positive SLR on the right, provocative cross leg raise on the left, provocative Kemp's testing for localized pain and right leg pain. Right Achilles reflex was diminished at 1/5 compared to the left side at +2/5. Dr. requested for a lumbar CT myelogram in order to delineate neural compression.

On April 21, 2009, D.C., denied the request for CT myelogram of the lumbar spine as it was not within the Official Disability Guidelines (ODG). The RME report by Dr. did not recommend additional surgery or a repeat CT myelogram. There was inadequate documentation to override the ODG or the RME reports. It was noted that the patient had attempted three surgical interventions with poor results.

On May 19, 2009, D.C., denied the appeal CT lumbar myelogram with post CT scan. Rationale: *"There is no indication that the claimant is under surgical consideration at this time. No recent orthopedic or surgical evaluations have been performed on this claimant and submitted indicating the need for the current request for this claimant. Based on the documentation provided, objective and subjective findings, this request is not medically reasonable and necessary."*

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

Based on the records provided, the claimant had an episode of lower back pain while at work that was determined to be a compensable injury and consequently underwent 3 lumbar surgeries that failed to resolve her complaints. There is no objective indication in the records that the surgeries provided years ago helped the claimant. She is maintained on medications for chronic pain. There is no indication in the records that further surgical interventions are planned. RME evaluation suggested that there is no support for further surgery due to the poor outcomes from surgery thus far. Invasive diagnostic procedures such as CT myelogram are not supported by ODG treatment guidelines or the records provided for review because this patient is not an established surgical candidate. Independent medical examination has not endorsed surgical intervention and the poor response to previous surgeries also favors non-surgical approach.

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