

# MATUTECH, INC.

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**DATE OF REVIEW:** June 19, 2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Follow up office visit with treating physician in March 2009

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

Fellow American Academy of Physical Medicine and Rehabilitation

**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 the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who twisted his lower back on xx-xx-xx.

**2007:** In December, M.D., noted the following treatment history: *Approximately xxxx years following the injury, magnetic resonance imaging (MRI) of the lumbar spine showed a herniated disc. He injured his neck in xxxx in a fall when his neck snapped in a whiplash type manner. He was treated with epidural steroid*

*injection (ESI) with short-term relief, surgery for his low back and neck in 2001. The surgery failed to improve his conditions. History was positive for CABG in 1992 and stents in 2006. Currently, he complained of low back pain radiating down the left leg to his feet, neck pain radiating into the shoulder blades, and headaches. He used a cane as he had frequent falling episodes. He was quite depressed. His medications included hydrocodone, gabapentin, Wellbutrin, alprazolam, and Soma. Dr. assessed lumbar herniated disc, lumbar radiculopathy, lumbar facet syndrome, depression, and anxiety. He stated the patient would require larger doses of medications in order to lead a more productive life and possibly either a spinal cord stimulator (SCS) or morphine pump. He prescribed Kadian, Norco, Zanaflex, and Cymbalta. Dr. gave a trial of intrathecal morphine, which gave relief of pain and ability to sleep without pain for approximately 12 hours. Dr. recommended placement of intrathecal pump.*

**2008:** From January through December, the patient had monthly follow-ups with Dr. for medication refills. Authorization for placement of morphine pump was awaited. Dr. noted that in an impairment rating evaluation, Dr. had stated the patient was suffering from somatization disorders. Dr. recommended SCS trial. The requests for psychological evaluation and SCS were denied. Dr. managed him with medications including Kadian, Norco, Zanaflex, Cymbalta, morphine sulfate ER, and Methadone.

In September, , M.D., performed a medical evaluation and noted the following: *In April 2005, Dr. recommended discontinuing hydrocodone and continuing antidepressants. He stated additional PT or DMEs would not be needed. The patient had been weaned off of most of drugs and should continue taking Celexa. In April 2006, the patient attended a pain management program at but was continued to be withheld from employment. Previous MRI showed bulging disc at L4-L5. The patient attended WHP. He was placed at MMI as of June 8, 1995, with 7% whole person impairment (WPI) rating. MRI in March 2007 showed postoperative changes with L4-L5 and L5-S1 fusion, degenerative changes at L3-L4 with mild acquired spinal canal stenosis at the far right with broad based disc protrusion narrowing the right neural foramen, and a broad-based disc protrusion at L2-L3. The patient continued to follow Dr. who managed him with medications in 2007. In July 2008, a designated physician stated the extent of injury was lumbar disc disease. The patient scored 47 on Beck Depression Inventory (BDI) consistent with severe depression and 42 on Beck Anxiety Inventory (BAI) consistent with severe anxiety. Dr. diagnosed major depressive disorders, in partial remission; undifferentiated somatoform pain disorder; and mood disorder secondary to CABG and stent placement. He opined: (1) Diagnosis of lumbar fusion and diagnosis of pain secondary to lumbar fusion were directly related to the work injury. (2) Major depressive disorder and undifferentiated somatoform pain disorder were not related to the work injury.*

**2009:** From January through March, the patient had follow-ups on a monthly basis with Dr. who continued Norco and Cymbalta.

On March 5, 2009, Dr. requested for monthly follow-up visits.

Per utilization review dated March 10, 2009, D.O., denied the request for monthly follow-up visits with following rationale: *"The request is for follow-up office visits with Dr for chronic back pain. The patient is receiving Norco 10 mg #180 and*

*Cymbalta 60 mg at bedtime. These medications can be renewed and monthly visits are not medically reasonable and necessary. The claimant was seen on March 3, 2008. The medications are not scheduled to narcotics. AT this the request is recommended for noncertification as they are not medically reasonable or necessary.”*

In April, Dr. appealed for monthly follow-up visits. He stated the patient had been seen in his office on monthly basis since December 2007. On these regular visits, the patient was prescribed Cymbalta and Norco. Norco was scheduled Narcotic. Monthly office visits and renewal of these prescriptions were medically reasonable and necessary.

On April 6, 2009, M.D., denied the appeal for monthly follow-up visits with the following rationale: *The request is reconsideration for monthly office visits for chronic low back pain. A peer-to-peer was placed for Dr, spoke with at 1:15 EST who reported that Dr. was not available. The records indicate that the claimant was status post lumbar laminectomy syndrome, lumbar radiculopathy, and lumbar facet syndrome. There is no indication that the claimant is having acute exacerbations and medication management. Medications appeared stable and can be renewed without the claimant being seen. Once every three month follow-up for assessment is reasonable and appropriate, but monthly is not.”*

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. AFTER REVIEW OF THE RECORDS, THE MEDICATIONS PRESCRIBED AND THE LACK OF ANY REPORTED ACUTE DETERIORATION IN THE INDIVIDUAL’S CONDITION DOES NOT SUPPORT THE NEED FOR MONTHLY OFFICE VISITS AND IS NOT RECOMMENDED BY ODG. OFFICE VISITS TWO TO FOUR TIMES PER YEAR IS REASONABLE AND WITHIN THE STANDARDS OF CARE.**

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

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