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Notice of Independent Review Decision

DATE OF REVIEW: 01/04/2010

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the

reviewer

and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the

utilization

review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Tests for back surgery: Outpatient EMG/NCV of the bilateral lower extremities, spiral CT, total bone scan

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 06-10-98 Review of Medical History and Physical Exam from Dr.
- o 12-03-99 Report of Medical Eval and Impairment Rating from Dr.
- o 01-19-99 Review of Medical History and Physical Exam from Dr.
- o 06-19-03 Designated Doctor Examination from Dr.
- o 09-26-03 Report of MMI from Dr.
- o 02-18-05 Muscle reassessment report from PT
- o 11-04-05 MRI lumbar spine read by Dr.
- o 02-08-06 Change of Address note from Dr.
- o 02-28-06 Lumbar radiograph report from Dr.
- o 02-28-06 Initial orthopedic report from Dr.
- o 04-04-06 Follow-up report from Dr.
- o 04-18-06 Procedure report facet injections from Dr.
- o 06-19-06 Procedure report, facet injection from Dr.
- o 08-28-06 Medical report from Dr.
- o 09-07-06 Medical report from Dr.
- o 10-12-06 Medical report from Dr.
- o 10-19-06 SI joint injection procedure report from Dr.
- o 10-19-06 IME report from Dr.
- o 10-24-06 Radiograph report from Dr.
- o 11-07-06 Medical report from Dr.
- o 12-13-06 Follow-up visit note from Dr.
- o 03-22-07 Follow-up report from Dr.
- o 05-23-07 Follow-up report from Dr.

- o 08-07-09 Follow-up report from Dr.
- o 09-05-07 Lumbar MRI read by Dr.
- o 09-13-07 Follow-up report and SI joint injection procedure report from Dr.
- o 10-18-07 Follow-up report from Dr.
- o 01-09-08 Follow-up and SI joint injection report from Dr.
- o 02-20-08 Medical report - facet injection - from Dr.
- o 05-31-08 Left knee x-ray report from Dr.
- o 06-03-08 Medical report from Dr.
- o 07-08-08 Initial Consultation report from Dr.
- o 09-19-08 Medical report from Dr.
- o 10-30-08 Medical report from Dr.
- o 04-08-09 Medical report from Dr.
- o 10-15-09 Radiographic Report from Dr.
- o 10-15-09 Initial Orthopedic Report from Dr. J.
- o 10-27-09 Preauthorization Request from Dr.
- o 10-30-09 Notice of Intent to Issue an Adverse Determination
- o 11-02-09 Initial Adverse Determination letter
- o 11-02-09 Request - Reconsideration for repeat BLE EMG/NCV from Dr.
- o 11-03-09 Acknowledgement of Reconsideration Request
- o 11-10-09 Notice of Utilization review Findings
- o 12-14-09 Request for IRO from the provider
- o 12-14-09 Notice of Assignment of IRO from TDI
- o 12-15-09 Confirmation of Receipt of IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the left knee and ankle on xx/xx/xx when the heel of her shoe caught on a hole (or she stepped in a 3-foot deep hole) and she fell.

She was treated for back, knee and ankle pain and underwent an arthroscopic surgery in October 1997 and a total knee replacement in 2001. The patient is 5' 2" and 208 pounds (or 5' 5" and 220 pounds).

An impairment evaluation was provided in December 1999 and a whole person impairment of 24% was assigned. The examiner noted flexion and extension measurements were invalid based on a significant variance between supine measurements and observed sitting straight leg raises. Left lateral flexion measurements were also invalid; ROM deficits were not reproducible. Sub-maximal effort with hand grip testing was noted. She had an EMG/NCV which showed mild S1 radiculopathy. She had two epidural injections and a discogram which showed an L3-4 positive disc. She underwent and IDET procedure which she reported was not very helpful. She is at statutory MMI.

The patient underwent a Designated Doctor examination on June 19, 2003 to determine if the claimant could return to work. She had two arthroscopic surgeries and then a total knee replacement in 2001. She continues to wear a brace on the left knee. She reports only several days of back pain relief with an IDET procedure in September 1999. Per IME opinions of January 2003 she is able to return to work but not at the same type of work previously held. The patient now reports she is unable to feel her legs and feet and has difficulty with control. She continuously trips. She is using a cane, a knee brace, a back brace and ankle supports. She likes Zanaflex for better sleep. She is taking real estate courses via the internet. She can do sedentary work. Between the knee and back the patient has a whole person impairment of 28%.

Lumbar MRI of November 4, 2005 was significant for right L5 nerve root impingement associated with a 5 mm herniation at L4-5. A free fragment was also seen at that level. There is mild narrowing of the right neuroforamen at L5-S1 associated with a disc herniation.

The patient's current orthopedic provider initially examined the claimant on February 26, 2006. She currently ambulates without an assistive device and does not wear a lumbar brace. She reports her condition has been worsening. She is 5' 5" and 214 pounds. Right quadriceps and EHL strength is 3/5. Recommendation is for Lunesta, Ultracet refills and bilateral lower extremity EMG/NCV.

Bilateral lower extremity EMG/NCV was performed on March 23, 2006 and interpreted to show bilateral chronic S1 radiculopathies. She has already had epidural injections with only brief relief. Recommendation is for facet blocks and repeat x-rays. She also needs posterior decompression at L4-5 and L5-S1. A fusion would not be indicated. Facet injections were provided at L4-5 on 04-18-06 and 06-19-06 and at L4-5 and L5-S1 on 09-07-06 (epidurals also provided same visit) and bilateral SI joint injections on 10-19-06 and 09-13-07. Brief relief was obtained from all injections.

The patient underwent an IME on October 19, 2006. Her monthly office visits may not be appropriate; this may be too frequent. Lumbar injections have not had a lasting benefit. Lyrica and Ultram are appropriate. She should not continue Lunesta. SI joint injection is recommended. Facet injections are not recommended. The IDET procedure made things worse. If SI injection is of minimal benefit recommend CT myelogram and then consider a decompressive laminectomy. She does not need chiropractic, PT, psyche pain management, or work conditioning. No DME is needed other than a cane or brace for the left knee. She should have yearly visits for her knee.

The most current lumbar MRI was performed on September 5, 2007 and was given impression of mild foraminal stenosis at L3-4

secondary to a circumferential bulge and facet arthropathy. Severe central canal stenosis at L4-5 and mild foraminal stenosis secondary to a circumferential disc bulge indenting the thecal sac with moderate-to-severe facet arthropathy and thickening of the ligamentum flavum. L5-S1 has a circumferential annular bulge with indentation of the thecal sac and description of mild bilateral foraminal stenosis.

On October 18, 2007 the patient reported a little bit of pain relief with the bilateral SI joint injections of September 13, 2007. She will be scheduled for repeat SI joint injections in November or December.

The patient underwent bilateral L5-S1 facet joint injections on January 9, 2008. She reportedly received significant relief from the prior SI joint injections. Her pain level however is noted as 7/10 (same as prior). On February 20, 2008 the patient reported the facet blocks relieved a portion of her pain (25% for 3 days). Additional blocks at level L4-5 are considered.

The patient underwent an orthopedic examination on July 8, 2008 for left knee complaints. The knee appears stable and the cause of her pain was not clear. She reports it periodically gets swollen and red. She should have lab work done and be seen by a fellowship trained joint replacement specialist.

At reevaluation on August 3, 2008 the patient was recommended to undergo radiofrequency ablation L3-S1. She desires to continue conservative measures versus a surgery.

On September 19, 2008 the patient reports persisting marked left knee pain. She was seen in consultation and no obvious loosening was seen of the prosthesis. She was recommended to see a joint specialist. She will be referred to a specialist for evaluation and possible revision. On October 30, 2009 the patient complained of bilateral knee pain. She brought a recent CT scan which showed moderate left suprapatellar effusion, small-to-moderate right suprapatellar effusion, otherwise no abnormalities. She is administered injections into the left greater trochanteric process.

On April 8, 2009 the patient returns after an absence. The report states she was last seen on June 3, 2008 when RFA was recommended. However this provider previously reevaluated the patient on September 19, 2008. In any case, the patient returns after an approximately 7-month duration. The patient is reported to be worsening with right tibialis anterior strength of 4/5 and left tibialis strength of 3/5 and bilateral EHL and hamstring strength of 3/5. Diagnosis is L4-5 canal stenosis and neurogenic claudication. She will discuss surgical recommendations with her family.

No reports are available between April 8, 2009 and October 15, 2009.

X-rays taken October 15, 2009 show significant spondylolytic findings throughout most of the lumbosacral spine. Incidentally noted is a compression fracture at T11 with a central herniation of both endplates at T11-12. The disc space of L1-2 is markedly narrowed. Central herniation of both endplates is suggested at L2-3. L3-4 has a slight narrowing with a double density indicating central herniation. L4-5 has marked narrowing of the disc space with sclerotic changes and marked rim lesions. L5-S1 has narrowing with facet hypertrophy and appearance of trophism of the facets.

At reevaluation on October 15, 2009 it was reported she falls probably two times a week. She reports a pain level of 8/10. She reports GI problems and weight loss (13 pounds) associated with loss of appetite. She was diagnosed with osteoporosis in 2007. She had breast cancer and a right mastectomy in April 2008. She has difficulty urinating with urgency which is becoming worse since 2007. Two months prior she had chest and left arm pain and underwent a stress test. She has been on hypertensive medication since 2004. She gets B12 shots every month for anemia. She ambulates slowly and uses a cane in the left hand. Straight leg raise increases back pain more so on the left. Left calf hypoesthesia is noted. All muscles appears weak and there is a cogwheel type giving away that makes testing difficult. The left SI joint is more tender than the right. Diagnosis is segmental spondylosis throughout the lumbosacral spine, less at L3-4, central and foraminal stenosis secondary to facet arthropathy, herniated disc and ligamentum flavum thickening per CT scan dated September 5, 2007, herniated discs, L2-3, L4-5 and L5-S1 per CT scan September 5, 2007, endplate fracture T11-12, L1-2, L2-3, L3-4 per x-rays dated October 15, 2009, sacroiliac joint dysfunction, lumbar radiculopathy, status post right mastectomy April 2008, breast cancer, status post left knee replacement 2001, and internal derangement right knee (by history). Recommendation is for spiral CT of the thoracolumbar spine, EMG/NCV, Celebrex and Voltaren gel.

Request for EMG/NCV of the bilateral lower extremities was considered in review on October 30, 2009 with recommendation for non-certification. Per the reviewer the examination of October 15, 2009 is the first examination in over two years (or more accurately, 6 months). There are no indications of a trial of conservative therapy and no neurological data on the most recent examination. Information provided was insufficient to recommend the procedure.

The provider responded with request for reconsideration: The patient was referred for nerve studies because of symptoms of radiculopathy with abnormal imaging studies. Her symptoms have worsened and she has not been studied in many months. According to ODG such a study is reasonable to identify radiculopathy when it is not clearly defined on examination, and in this patient no such lateralized abnormality is identified on examination and her reflexes are generally hypoactive and difficult to assess. The recommendation for additional conservative treatment is long outdated as she is well into the chronic stage of her disease with the date of injury many years ago. Based on her symptoms and findings, a repeat electrodiagnostic study at this time is felt to be medically necessary and reasonable.

Request for reconsideration EMG/NCV of the bilateral lower extremities was considered in review on November 10, 2009 with recommendation for non-certification. The patient has had multiple studies including MRI, CT scans and EMGs without a true diagnosis. The studies disclosed multiple degenerative changes of the lumbar spine and multiple bulging discs. MRI disclosed

the possibility of a herniated disc with fragments at the L4-5 level. There are no complete physical or neurological examinations or a clear description of the pain evaluation. The examination of 10-15-09 shows only a limited evaluation if the claimant's pain with no identification of the pain distribution. The neurological examination is limited and unremarkable. During the examination, the claimant shows that there were definite functional deficits, but the subjective responses during the examination were not credible. The claimant is 5' 2" and 208 and obese. Throughout the documentation reviewed, she did have a psychiatric diagnosis of multiple anxiety, depression and PTSD. She is known to have hypertension and is taking 8 types of different medications. Also in the record the claimant has complained of multiple pain including chest, pain, shoulder pain, arm pain, multiple allergies, anemia and fatigue etc. A repeat lower extremity EMG/NCV will not help identify the pain generators that are organic and functional. In the final diagnoses there is no identification of the generating pain factors. There are 10 diagnoses. This claimant will not benefit from a repeat EMG/NCV but is likely to benefit from a thorough evaluation by an internist for the multiple complaints that she has. The documentation does not meet the ODG criteria for EMG/NCV.

Request was made for an IRO.

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

According to ODG: EMG is recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious.

Bones scans are not recommended, except for bone infection, cancer, or arthritis.

CT myelography: OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive.

The patient is overweight and deconditioned. She was treated for low back pain from 1997-1999 and provided a whole person impairment in December 1999 when she reached statutory MMI. Per the MMI examiner, flexion and extension measurements were invalid based on a significant variance between supine measurements and observed sitting straight leg raises. Left lateral flexion measurements were also invalid; ROM deficits were not reproducible and sub-maximal effort with hand grip testing was noted. The patient did have an EMG/NCV which showed mild S1 radiculopathy. The patient underwent left total knee replacement in 2001. Approximately 2 years later in June 2003 the patient began reporting she is unable to feel her legs and feet as if unable to control them. She is given a whole person impairment of 28%. It was noted that the patient has been on hypertensive medication since 2004. In February 2006, over 9 years post injury, she reports her condition has been worsening. She is 5' 5" and 214 pounds. Right quadriceps and EHL strength is 3/5. Repeat EMG/NCV was performed and again showed, bilateral chronic S1 radiculopathies. She has already had epidural injections with only brief relief. Recommendation was for facet blocks and consideration of posterior decompression at L4-5 and L5-S1. She was provided additional epidural injections, facet blocks and SI joint injections. An IME was conducted in October 2006 and determined appropriate treatment would be SI injection followed by CT myelogram and consideration of a decompressive laminectomy if the SI injections were not helpful. Additional facet and epidural injections were not supported.

The patient underwent a repeat MRI on September 5, 2007 which revealed mild foraminal stenosis at L3-4 secondary to a circumferential bulge and facet arthropathy, severe central canal stenosis at L4-5 and mild foraminal stenosis secondary to a circumferential disc bulge indenting the thecal sac with moderate-to-severe facet arthropathy and thickening of the ligamentum flavum. At L5-S1 there is a circumferential annular bulge with indentation of the thecal sac and description of mild bilateral foraminal stenosis.

In late 2007 and during 2008 the patient was provided additional SI joint and facet injections. The patient was diagnosed with osteoporosis in 2007. In August 2008 she was recommended radiofrequency ablation L3-S1. The patient's knee condition became the focus of treatment during the latter part of 2008. The patient was diagnosed with breast cancer and had a right mastectomy in April 2008. In April 2009 the patient is seen again after a 7 month absence - per examination, right tibialis anterior strength is 4/5, left tibialis strength is 3/5 and bilateral EHL and hamstring strength is 3/5. Diagnosis is L4-5 canal stenosis and neurogenic claudication. She will discuss surgical recommendations with her family. The patient then disappears from the record for about 6 months. At presentation on October 15, 2009 the patient reports falling about two times a week. She reports a pain level of 8/10. She reports GI problems and weight loss (13 pounds) associated with loss of appetite. She had breast cancer and a right mastectomy in April 2008. She has difficulty urinating with urgency which is becoming worse since 2007. Two months prior she had chest and left arm pain and underwent a stress test. She has been on hypertensive medication since 2004. She gets B12 shots every month for anemia.

Despite IME recommendations for SI joint injections only and consideration for surgery, she has been provided repeated ESI and facet injections. Per ODG, EMG's are not necessary if radiculopathy is already clinically obvious. As chronic S1 radiculopathy is already well established in the two previous nerve studies, the rationale for a repeat study is lacking. The patient has been reporting tripping and lack of feeling in her legs and feet since 2003. She has been found to have severe stenosis at L4-5 with neurogenic claudication. Additionally, the patient appears to have internal medicine problems that are require more emergent assessment than her industrial knee and back conditions. The rationale for spiral CT and a total bone scan in regard to the patient's industrial knee and back conditions is not clarified. As the patient has recently had surgery for breast cancer and reports loss of appetite and loss of weight, internal medicine testing appears more important than repeat nerve studies for her chronic industrial back condition. CT myelography is not supported unless MRI is unavailable or contraindicated, conditions not documented for this patient.

Therefore, my recommendation is to agree with the previous non-certification of the request for tests for back surgery: Outpatient

EMG/NCV of the bilateral lower extremities, spiral CT, total bone scan.

The IRO's decision is consistent with the following guidelines:

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
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

The Official Disability Guidelines - Lumbar Chapter (12-18-2009):

EMGs:

Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended.)

The Official Disability Guidelines - Lumbar Chapter (12-18-2009): Bone Scan:

Not recommended, except for bone infection, cancer, or arthritis. [Note: This is different from the 1994 AHCPR Low Back Guideline, which said "Recommend if no improvement after 1 month" for Bone scan.] Bone scans use intravenous administration of tracer medications to show radioactive uptake to detect metastases, infection, inflammatory arthropathies, significant fracture, or other significant bone trauma.

The Official Disability Guidelines - Lumbar Chapter (12-18-2009): CT:

Not recommended except for indications below for CT. CT Myelography OK if MRI unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography (CT) without a clear rationale for doing so. A new meta-analysis of randomized trials finds no benefit to routine

lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients.

Indications for imaging -- Computed tomography:

- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, infectious disease patient
- Evaluate pars defect not identified on plain x-rays
- Evaluate successful fusion if plain x-rays do not confirm fusion (Laasonen, 1989)