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Notice of Independent Review Decision

DATE OF REVIEW: June 22, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar MRI with contrast, 75149

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

Fellow American Academy of Orthopaedic Surgeons

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

- Operative notes (02/19/01 – 03/16/06)
- Reviews (12/28/04 – 04/15/07)
- Diagnostics (03/14/05)
- Office visits (03/21/06 – 05/26/10)
- Utilization reviews (05/18/10 - 05/27/10)

Dr.

Office visits (08/15/06– 05/26/10)

xxxxxxx Center

- Operative notes (01/18/99 – 03/16/06)
- Office visits (08/11/99 - 04/30/10)
- Diagnostics (02/21/06)
- Therapy (11/16/06 – 07/31/07)
- Initial review (05/18/10)

TDI

- Utilization reviews (05/18/10 - 05/27/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a worker with a work-related injury in xx/xx , when he was bending over and developed low back pain.

1999 – 2001: On January 18, 1999, M.D., an orthopedic surgeon, performed decompressive laminectomy, foraminotomy, discectomy, posterior lumbar interbody fusion (PLIF) at L5-S1 for the diagnosis of painful degenerative disc disease (DDD) at L5-S1 and intractable low back pain. The patient was discharged home in a stable condition with prescription for Vicodin.

In May 1999, M.D., noted minimal improvement in symptoms following the procedure. The patient complained of low back pain radiating to the left knee with no benefit from epidural steroid injection (ESI) and physical therapy (PT). Examination revealed antalgic gait, very limited range of motion (ROM), tenderness over the midline of the lumbar spine and positive straight leg raise (SLR) test on the left.

The patient was admitted to xxxxxxxx for further evaluation by a multidisciplinary team. Psychiatric testing showed significant levels of anxiety, depression, fear and frustration over the current physical and psychosocial situation. The patient was deemed to be an excellent candidate for chronic pain management and comprehensive pain program.

On January 1, 2000, Dr. performed bilateral L3, L4, and L5 laminectomy with medial facetectomy and foraminotomy at L3-L4 and L4-L5 for the diagnosis of L3-L4 and L4-L5 spinal stenosis with severe back and left leg pain.

In October 2000, Dr. performed T11-T12 laminectomy with placement of intraoperative trial of spinal cord stimulator (SCS).

On February 19, 2001, Dr. performed L4-L5 decompression and PLIF and L4-L5-S1 posterolateral fusion using Silhouette screw and rod system.

2002 – 2003: No records are available.

2004 – 2007: On December 28, 2004, M.D., performed a required medical evaluation (RME) and noted the following: *The patient quit smoking in 1972. He had daily headaches since the first operation and his headaches were getting worse. He utilized medications for headaches and refilled them (Inderal) from his family doctor. He had tried Elavil, Toprol and Imitrex without any relief.* Dr. opined: (1) The treatment rendered appeared to be related to the work event. (2) There appeared to be a causal relationship between the work and the reported symptoms/surgical intervention. (3) The prognosis was fair and additional follow-up with his treating doctor was needed. The SCS caused weakness, and re-evaluation by Dr. would be needed in the near future. (4) The patient was not taking any current prescription medications that were related to the work event.

From February 2005 through March 2006, the patient had regular follow-up visits with Dr. Dr. obtained computerized tomography (CT) of the lumbar spine, which showed: (1) Solid anterior fusion at L5-S1. (2) Right L4-L5 facet joint appeared to be fused, but there was some haloing around the inferior plate of the L4 slightly worrisome for a nonunion of anterior portion of the fusion. (3) Central canal stenosis at L2-L3 and L3-L4, related to a developmentally small canal, posterior ligamentous fibrosis and bilateral facet arthrosis. The patient had completed three ESIs. The first and second injections were somewhat helpful, but the last injection provided relief only for a few weeks. Dr. assessed retained SCS system, L3-L4 stenosis above L4 to sacrum fusion and retained left L4 to sacrum screw and rod system. He planned removal of the same.

In January 2006, Dr. opined the treatment rendered appeared to be related to the work event and there appeared to be a causal relationship between the work event and the reported symptoms. The SCS removal was a reasonable option since it was not working. The patient had failed back syndrome as related to the work event and had reached maximum therapeutic potential in regards of his care.

In February 2006, lumbar myelogram showed significant narrowing at L3-L4, and postsurgical changes from L4-S1. A post-myelogram scan showed: (1) Postsurgical changes from L4-S1. (2) Congenital central canal stenosis secondary to short pedicles. (3) Discogenic or spondylotic changes, most prominent at L3-L4 with mild annular disc bulge, facet arthrosis and short pedicles combining to produce moderate-to-severe central canal stenosis with mild-to-moderate bilateral foraminal stenosis and compression of the thecal sac.

On March 15, 2006, Dr. performed removal of L4 disc screw and rod system with exploration of L4 to sacrum system with utilization of locally harvested bone and bone morphogenic protein, L3-L4 laminectomy and medial facetectomy for decompression, and removal of SCS system with laminectomy approach. Dr. prescribed Ambien for postoperative sleep disturbance and Darvocet for pain control.

From November 2006 through July 2007, the patient attended therapy. The patient was provided a transcutaneous electrical nerve stimulation (TENS) unit and neuromuscular electrical stimulation (NMES) unit.

On April 15, 2007, Dr. opined the treatment rendered appeared to be related to the work event; the patient required ongoing medical management in the form of possible prescription medications though Elavil and Topamax did not provide any relief. Office visits on a semiannual to yearly basis would be considered reasonable and necessary and the patient should continue with a home exercise program (HEP) on his own accord.

2008 – 2009: No records are available.

2010: In April, the patient reported increased back pain (pain score of 5/10) over the last year or so with some leg pain on ambulation. He denied any new accident or injury, and denied any recent diagnostic studies, therapy or injections. Bilateral SLR reproduced back pain. X-rays were consistent with

solid L4 to sacrum fusion. Dr. assessed possible lumbar stenosis and ordered a lumbar MRI for further evaluation.

On May 18, 2010, , M.D., denied the request for MRI of the lumbar spine with the following rationale: *“There is insufficient objective clinical evidence of progressive neurologic deficit on physical exam to warrant this request as medically necessary at this time. X-rays dated April 30, 2010, report that the patient has a stable fusion. There was a three year gap in clinical documentation from 2007 to 2010. There is also no clinical documentation submitted for review, of failed efforts of conservative care such as recent course of PT. Official Disability Guidelines (ODG) states that repeat MRIs are indicated only if there has been progression of neurological deficit. As there is insufficient objective clinical evidence of a progression of neurological deficits, this request cannot be certified at this time.”*

On May 26, 2010, Dr. requested reconsideration for the MRI.

On May 27, 2010, M.D., denied the appeal for lumbar MRI with the following rationale: *“The clinical note dated xx/xx/xx , stated that there were complaints of back pain with limited lumbar ROM and bilaterally decreased Achilles reflex. The suspected pathology at this time is spinal stenosis. The patient has already undergone decompression surgeries for previous radiological findings of stenosis. However, the current development of symptoms does not point to nerve root compromise, the pain complaint that was presented was not described to be radicular in character. The symmetry of documented reflex dysfunction in the absence of sensory and motor deficits also fails to support the presence of nerve root compromise due to spinal stenosis.”*

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

THE REQUEST HAS BEEN FOR AN MRI WITH CONTRAST TO THE LUMBAR SPINE. THE AVAILABLE DOCUMENTATION REVIEWED, DOES NOT HAVE THE PATIENT HISTORY, PHYSICAL EXAMINATION AND REASON WHY THE MRI SCAN IS BEING REQUESTED BY THE PATIENT’S TREATING PHYSICIAN, DR. MILANI. THERE IS ONLY AN INTAKE H&P FROM APRIL 23, 2010, FOR THE PATIENT BUT NO PHYSICAL EXAMINATION. ODG GUIDELINES STATE FOR REPEAT MRI SCAN THERE HAS TO BE DOCUMENTED PROGRESSION OF NEUROLOGICAL SYMPTOMS. SINCE THERE IS NO PHYSICAL EXAMINATION PRESENT FOR REVIEW AND/OR HISTORY OR REASON WHY THE PATIENT NEEDS THE MRI SCAN, THE DECISION IS UPHELD IN AGREEMENT WITH THE PREVIOUS DECISIONS OF DR. CLARK AND DR. GARCIA.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**