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Notice of Independent Review Decision

DATE OF REVIEW: September 13, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar CT myelogram

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

- Procedures (02/03/09 – 08/02/10)
- Office Visits (02/11/10 – 08/12/10)
- Utilization review (07/28/10 – 08/23/10)
- Diagnostics (08/13/10)
- Reviews (10/09/10)

- Diagnostics (11/17/06 – 02/08/10)
- Office Visits (05/31/07 – 08/12/10)
- Procedures (06/22/07 – 08/02/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

PRE – INJURY RECORDS: The patient had a sprain in his neck and back in when trying to hold a machine that was falling. Magnetic resonance imaging (MRI) of the lumbar spine was obtained and revealed: (1) Mild bilateral spondylosis associated with grade I spondylolisthesis of L5 on S1 measuring 7 mm in neutral position and discogenic sclerosis on both sides of the disc level. (2) Pseudo disc bulge complicated by minimal degenerative disc bulge abutting both traversing S1 nerve root sleeves, but neither was deflected. There was moderately severe neural foraminal narrowing bilaterally due to osteophyte overgrowth at the site of the spondylolysis defect. Both exiting L5 nerve roots were likely to be affected. (3) Ligamentum flavum hypertrophy indenting the dorsal thecal sac at the L4-L5 level. The patient was diagnosed with dominant lumbosacral pain, right side dominant probably facetogenic or discogenic in

etiology, secondary right lower extremity pain with right L5 and S1 radiculopathy; and treated him with right S1 and right L5-S1 transforaminal epidural steroid injection (ESI), medications and physical therapy (PT). The lumbar facet injections provided one week of relief from pain. A lumbar discogram was suggested in order to offer diagnostic information regarding the potential discogenic sources of pain.

POST-INJURY RECORDS

2007 – 2008: The patient returned to, M.D., informing that he had a re-injury while at work when he fell in. He complained of increased pain in the lower back and right lower extremity and occasional left lower extremity pain. *He had attended PT in 2007 which had not improved his condition and had received a facet joint injection in the lumbosacral area which provided 80% relief for approximately one-and-a-half weeks. He was tried on NSAIDs and had developed stomach ulcers and therefore discontinued them.*

On December 5, 2007, the patient underwent a right L5-S1 transforaminal ESI which provided three days partial relief of pain. He was started on fentanyl patches, Neurontin, Ambien CR, and Norco for breakthrough pain. An MRI obtained showed large disc herniation and spondylolisthesis. Melatonin and Ambien CR were prescribed to help the patient sleep well.

2009 – 2010: In January, the patient suffered a muscle strain for which he took muscle relaxants.

On February 3, 2009, M.D., performed anterior lumbar interbody fusion with partial corpectomy, at L5-S1; instrumentation with PEEK implant at L5-S1; Gill procedure at L5-S1; posterolateral fusion bilaterally at L5-S1, posterior segmental instrumentation bilaterally at L5-S1 and left iliac crest graft.

Postoperatively, it was suggested that he wean off Norco and decrease the fentanyl patches as tolerated. Ambien was discontinued and Lunesta added p.r.n. for insomnia. However, the patient continued to have back and lower extremity pain, right greater than left; and paresthesias in the upper extremity that was suspected due to carpal tunnel syndrome (CTS).

In a designated doctor evaluation (DDE), M.D., placed the patient at maximum medical improvement (MMI) as of September 15, 2009, and assigned whole person impairment (WPI) of 5%. The patient was released to work with restrictions.

The patient continued to complain of numbness down the posterior midline aspect of the upper extremity bilaterally and reported that he dropped tools while at work more often. The numbness woke him up at night. He also complained of a sharp, stabbing pain and aching in the midline lumbosacral area. On examination, the mid trapezius and rhomboids were tender (right greater than left) and Spurling's was positive on the right. Dr. assessed axial cervical pain and right greater than the left arm pain, reversal of kyphosis at C5-C6 with disc degeneration and protrusion at C5-C6 and C6-C7. At C5-C6, the patient had a more left side protrusion creating left greater than right lateral stenosis and mild central canal stenosis and at C6-C7. He had a right-sided posterolateral

protrusion creating moderate-to-severe right lateral stenosis. Dr. felt the patient would have cervical radiculitis caused by the disc protrusions.

MRI of the cervical spine revealed: (1) Cervical kyphosis and spondylosis with disc bulge creating mild AP cord flattening at C5-C6. (2) Foraminal compromise bilateral at C5-C6 more so than the right C6-C7, enough that there was potential for irritation of bilateral C6 more likely than right C7 nerve roots. (3) Thoracic spine spondylotic curvature was incompletely evaluated.

The patient continued to have dominant neck pain. The fentanyl dosages were changed and he underwent a C7-T1 interlaminar ESI in April.

On April 29, 2010, Dr. noted that the patient was doing well with regards to the lumbar spine and was now being treated for cervical spine. X-rays showed an acceptable alignment of the lumbar hardware. There was no evidence of hardware loosening and but solid bone consolidation at the surgical site.

As the patient continued to have ongoing neck complaints, a left C5-C6 transforaminal ESI was performed which provided relief for 8 to 10 days.

In July, the patient complained of pain radiating down his right buttock and right posterior thigh aggravated by standing, walking and bending. He was then referred to another pain management physician for his lumbar pain complaints and was given a trial of Suboxone. A computerized myelogram (CT)/myelogram of the lumbar spine was requested by Dr..

On July 28, 2010, the carrier denied the request for lumbar CT myelogram with the following rationale: *“Clinical documentation indicates the patient underwent an anterior lumbar interbody fusion (ALIF) at the L5-S1 level with instrumentation on February 3, 2009. Postoperative radiographs revealed acceptable alignment of hardware, no evidence of hardware loosening and evidence of solid bony consolidation. No clinical rationale was provided as to why the patient is being recommended for CT myelogram of the lumbar spine. There is no indication that the patient has undergone recent conservative care for lumbar spine symptoms. Additional clinical documentation would need to be submitted for review before the appropriateness of this request could be established.”*

In August, Dr. performed right L5-S1 transforaminal ESI for persistent low back pain. He requested a reconsideration of CT lumbar myelogram.

On August 23, 2010, the appeal was denied with the following rationale: *“Patient complains of lumbosacral pain. Pertinent findings include tenderness in the right lateral calf and in the axial lumbosacral area, positive SLR bilaterally, and normal motor, sensory and reflexes in the bilateral lower extremities. The rationale of this request is to assess integrity of fusion; however, the radiographic studies have already confirmed solid fusion. Moreover, the neurologic findings did not show neurologic deficits or red flag sign. There is no objective documentation of conservative care recently done to address lumbar symptoms. As such, the medical necessity of this request is not fully established at this time.”*

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

This individual's radiographs revealed excellent alignment and solid bone formation at the surgical site. ODG criteria, as related to the lumbar spine, to include evaluation of the success of fusion if not confirmed on x-ray and lumbar trauma with neurologic deficits, which is not the case. Therefore, based ODG the medical necessity for the CT myelogram has not been established.

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