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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 13, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

99213 Doctor *Visit* (09/10/10, 12/28/10).

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

American Board of Physical Medicine & Rehabilitation
American Board of Pain Medicine

REVIEW OUTCOME

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

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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- Office visits (04/05/05 – 01/27/11)
- Diagnostics (03/01/05 – 11/27/06)
- Operative notes (03/02/06 – 08/06/09)
- Review (05/11/10)

Dr.:

- Office visits (04/22/08 – 04/05/05)
- Diagnostics (03/01/05 – 11/27/06)
- Operative notes (03/02/08 – 08/06/09)

Dr.

- Office visits (04/05/05 – 01/27/11)
- Diagnostics (03/01/05 – 11/27/06)
- Operative notes (03/02/06 – 08/06/09)
- Review (05/11/10)
- Review (05/11/10)
- Bills (09/10/10 – 12/28/10)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who felt immediate pain in his lower back.

2005 – 2008: On March 1, 2005, magnetic resonance imaging (MRI) of the lumbar spine revealed 1-cm area of marrow edema involving the anteroinferior T12 vertebral body and an area of posttraumatic marrow contusion; 1 cm hemangioma at the L2 vertebral body; Schmorl's nodes at the superior endplate of the L3 vertebral body and small central annulus tear with a

small central disc protrusion at the L4-L5. M.D., an orthopedic surgeon, evaluated the patient for low back pain with episodic leg pain. He noted that the patient was originally diagnosed with muscle spasms and back sprain. He was treated with eight sessions of physical therapy (PT) at Humpal, but without help and medications including hydrocodone, nabumetone and a muscle relaxer. Dr. reviewed MRI findings and diagnosed L4 central disc protrusion with posterior annular tear, L5 disc bulge and lower extremity radiculitis. He recommended continuing PT and a trial of epidural steroid injection (ESI).

Lumbar discogram revealed concordant mid back pain at L4-L5 and L5-S1. Post discogram computerized tomography (CT) scan of the lumbar spine revealed posterior annular tears at L4-L5 and L5-S1 associated with minimal disc bulges.

On March 2, 2006, Dr. performed percutaneous discectomy at the L4-L5 and L5-S1.

In November 2006, MRI of the lumbar spine revealed 1 cm area of T1 slightly hyperdense and T2 bright area identified anterior-inferior T12 vertebral body; small Schmorl's nodes at the superior endplate of L3 and anterior-superior endplate of T11 vertebral bodies and central annulus tear with central disc protrusion at L4-L5. This examination remained unchanged as compared to the prior examination. The patient was kept off work by Dr.

In April 2008, Dr. evaluated the patient for back pain radiating down both lower extremities with weakness, left greater than right and occasional numbness in both legs. The patient reported that his symptoms had worsened over the last six months. History was positive for chronic nicotine. Examination revealed marked left-sided paraspinal spasm slightly on the right. Unloading maneuver was positive for relief of back pain. Hamstring tightness was noted on seated SLR with some left sided-back pain. Dr. diagnosed internal derangement of L4 and L5 with lumbar discogenic pain syndrome and episodic lower extremity radiculitis. He opined that he had nothing to offer to the patient surgically as the patient was already receiving supportive medication through the office of Dr. He recommended a trial of spinal cord stimulator (SCS) which might substantially reduce the patient's complaints that would obviate the need for prescription pain medication in the future and increase the patient's ability to perform sedentary to light activity at work in the future.

2009: In February, the denial for an office visit (99213) and single drug screen (80101) was overturned through an Independent Review Organization process. The IRO report indicated the following: *On January 10, 2007, Dr. placed the patient at maximum medical improvement (MMI) with 5% whole person impairment (WPI) rating. From June 2007 through August 2008, Dr. managed the patient with Soma, Lortab, fentanyl, hydrocodone, Duragesic, Lyrica, and naproxen. On August 5, 2008, Dr. performed implantation of two Medtronic octads electrodes and SCS programming.*

Dr. noted the patient received at least 50% pain relief with SCS trial. History was positive for cancer and skin grafting. He diagnosed chronic pain syndrome, lumbar back pain and lumbosacral radiculitis and prescribed Lortab and Naprosyn. N.P., recommended methadone, Lortab and Flexeril.

On August 6, 2009, the patient underwent implantation of two octad electrodes into the epidural space at T8, T9 and T10 for SCS, programming and implantation of programmable pulse generator. Postoperatively, the patient reported pain associated with numbness, intermittent with sitting and poor sleep. He reported that stimulator turned off more often as he was getting over stimulation with movements. Ms. reprogrammed SCS and recommended continuing

Lortab and Flexeril. The patient was recommended to stop methadone. From October through December, the patient was seen by Dr. for back pain. He reported that the pain was improved by medications, rest and SCS implant but not as much as the trial had helped. Dr. recommended continuing Lortab and Flexeril.

2010: From January through November, the patient was seen by Dr. on a monthly basis who continued Lortab and Flexeril; reprogrammed SCS and ordered CT scan of the lumbar spine. He also tried Ultram ER for increasing pain but that was discontinued later on.

On May 11, 2010, M.D., performed a required medical evaluation (RME) and rendered the following opinions: (1) the patient needed an aggressive strengthening exercise program instead of IDET and SCS which were inappropriate. (2) The patient was seeing Dr. for four years with absolutely no changes. (3) Future treatment consisting of aggressive home exercise program (HEP) at least three times a week indefinitely was reasonable. He only needs to see a doctor every six months. (4) Lortab two to three times per day and Naprosyn in the form of over-the-counter (OTC) gel cap was appropriate. Muscle relaxants were not appropriate. No weaning was required.

From November through December, the patient was seen by Dr. for pain located in the back and right leg associated with weakness. The urine drug screen was appropriately positive for opiates, oxycodone and TCA. Surgical history was positive for bilateral shoulder injections and ESI at L4-L5 in 2005. The patient was diagnosed with chronic pain syndrome, long-term use of other medications, lumbar back pain and lumbosacral radiculopathy. Dr. recommended continuing Lortab and recommended CT lumbar spine.

2011: On January 27, 2011, Dr. evaluated the patient for back pain and right leg pain with weakness and recommended continuing Lortab.

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

THE PATIENT IS RECEIVING CHRONIC PAIN MEDICATIONS. UNDER THE CRITERIA FOR LONG-TERM USERS OF OPIOIDS (GREATER THAN 6 MONTHS) THE ODG STATES THAT THERE IS NO SET VISIT FREQUENCY. FURTHERMORE, THE VISIT FREQUENCY SHOULD BE ADJUSTED TO THE PATIENT'S NEED FOR EVALUATION OF ADVERSE EFFECTS, PAIN STATUS, AND APPROPRIATE USE OF MEDICATION, WITH RECOMMENDED VISITS FROM 1 TO 6 MONTHS. IN MY OPINION, THE FREQUENCY OF VISITS IS WITHIN THE ODG AND THE VISITS MEET THE CRITERIA FOR A 99213 CODE.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES