

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** August 10, 2011

**IRO CASE #:**

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

L2/3/4/5 transforaminal left SNRB (64483 and 64484)

**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  
Member of PASSOR

**REVIEW OUTCOME**

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

X Overturned (Disagree)

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Diagnostic (06/22/11)
- Office visits (06/29/11)
- Utilization reviews (07/05/11 – 07/12/11)
  
- Diagnostics (12/22/10 - 06/22/11)
- Utilization reviews (07/05/11 – 07/12/11)
- Office visits (11/20/11 – 07/07/11)
  
- Office visits (06/29/11 – 07/18/11)
- Diagnostic (06/22/11)
- Utilization reviews (07/05/11 – 07/12/11)

**TDI:**

- Utilization reviews (07/05/11 – 07/12/11)

**ODG has been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was walking under a hoist when a safety plate slipped and he fell onto his elbow and back resulting in severe injuries to his back on xx/xx/xx.

**2001 – 2005:** In November 2001, D.O., evaluated the patient for pain in the lower back and middle back, pain in the mid upper back and area between the shoulders, pain in the neck, radiating pain in to the back of upper leg, knee and calf on the left, numbness in the upper leg, stiffness in the lower back, spasm in the lower and middle back and tingling in the back of the upper leg, back of the knee, calf and the heel and the bottom of the foot on the left, loss of sleep and headaches. Examination showed decreased range of motion (ROM) in the lumbosacral spine, thoracolumbar spine and mid thoracic spine. Dr. diagnosed lumbar post laminectomy syndrome and lumbar pain. The patient reported he had stomach problems and had stopped taking Neurontin. Dr. refilled Darvocet and Ambien.

M.D., performed a peer review and rendered the following opinions: (1) The patient had lumbar injury and had undergone an anterior fusion with hardware. His back complaints could certainly be tied to the lumbar surgery. (2) Medications consisting of Ambien, Darvocet N-100 and Neurontin were appropriate. (3) The patient would have a very long-term chronic pain type situation.

From February 2002 through August 2003, the patient had multiple follow-up visits with Dr. for pain to the lumbar back, thoracic back, interscapular region, posterior neck and leg on the left; numbness of the leg on the left; stiffness of the lumbar back, thoracic back and the posterior neck; spasms of the lumbar back, thoracic back and posterior neck; tingling of the leg and the foot on the left and worsening of symptoms with trouble sleeping and headaches. He was diagnosed with postlaminectomy syndrome of the lumbar region and lumbago and was given refills of medications and recommended to do McKenzie extensions at home.

From November 2003 through October 2005, the patient was treated by , M.D. It was noted that the patient was status post 360 fusion at L5-S1 performed by M.D., in 1996. Examination revealed tenderness over the mid to lower paralumbar musculature predominantly from about the L4 to S1 levels; moderate tenderness over the sacroiliac (SI) joint areas bilaterally and inability to move with a distinctly antalgic gait. Dr. Townsend diagnosed lumbar sprain/strain/posttraumatic myositis; lumbar spine herniated nucleus pulposus (HNP) status post 360-degree fusion; chronic pain syndrome and lumbar radicular syndrome/lower extremity radicular symptoms. He refilled Darvocet N-100 and Ambien.

From May through November 2005, Sherine Reno, M.D., treated the patient with compounded cream consisting of ketamine 10, GABA 6, clonidine 0.2 and lidocaine 2%.

Per adjuster's note the patient had reached maximum medical improvement (MMI) on January 5, 1995, with 11% whole person impairment (WPI) rating.

**2006 – 2009:** From January 2006 through December 2009, the patient was treated by Dr. M.D.; Dr. and M.D., for ongoing episodically severe low back pain and decreased ROM and severe back spasms. He underwent x-rays of the lumbar spine that revealed an expected postoperative appearance for laminectomy and metallic fixation with IP screws and posterior metallic vertical rods, complete bony interspace fusion and possible osteoarthritis. He was treated with Ambien, Darvocet N-100, Lyrica, compound cream, Xanax, Flector patches, trazodone and baclofen. He was recommended Low-Pro LSO brace, twist stim and bottles of analgesic cream and was ordered electrodiagnostic studies.

**2010:** In 2010, the patient was evaluated by Dr. and M.D., pain management, for aching, numbing, stabbing, burning, sharp, constant pain in the lower back. The patient underwent computerized tomography (CT) scan of the lumbar spine that revealed a 3-mm central disc protrusion with borderline canal stenosis at L2-L3, broad 1-2 mm disc bulge at L4-L5 and stable postsurgical changes with L5-S1 posterior spinal fusion. The patient received refills of medications and was recommended spinal cord stimulator (SCS) trial by Dr.

**2011:** From January through May, Dr. treated the patient for worsening problems with Opana and other medications. In May, CT myelogram of the lumbar spine revealed a 4-mm central and left paracentral protrusion with mild central canal stenosis and potential left L3 nerve root impingement; broad 1-2 mm disc bulge at L4-L5 and status post posterior spinal fusion at L5-S1.

From May through June, Dr. treated the patient with medications and recommended a left transforaminal ESI at L2, L3, L4 and L5. He referred the patient to an orthopedic surgeon.

A second opinion regarding CT myelogram of the lumbar spine was obtained from M.D. He rendered following opinions: (1) A ventral impression at L2-L3 level measuring 3 mm anterior to posterior and 15 mm left to right with a slightly larger left greater than right component consistent with a central disc protrusion and flattening of the ventral aspect of the thecal sac. (2) Ligamentum flavum hypertrophy at L4-L5, triangular appearance to the spinal canal and left greater than right neural foraminal narrowing and approximately 4 x 12 mm left far lateral disc protrusion contacting the left L4 dorsal root ganglion. (3) Surgical changes at L5-S1.

Per utilization review dated July 5, 2011, the request for L2, L3, L4 and L5 transforaminal left SNRB was denied with the following rationale: *“The request for L2, L3, L4 and L5 transforaminal left SNRB, 64483, 64484 is non-certified. Documentation states the patient has complained of low back pain with numbness into the lower extremities. Evidence-based guidelines state that radiculopathy must be documented and objective findings on examination need to be present and corroborated by imaging studies. There was no diagnostic imaging submitted for review. There also was a lack of documentation submitted to reflect failure of conservative care to include medication management and physical therapy. Furthermore, guidelines state that no more than two nerve root levels should be injected in one session. Therefore, the request for L2-5 transforaminal left SNRB, 64483 and 64484 is non-certified.”*

On July 7, 2011, M.D., an orthopedic surgeon, evaluated the patient for back pain and bilateral leg pain. The patient reported thigh aching and burning and weakness in both legs. Dr. opined Dr. should perform some hardware injections to see if the patient can get any relief with that approach.

Per reconsideration review dated July 12, 2011, the appeal for L2, L3, L4 and L5 transforaminal left SNRB, 64483 and 64484 was denied with the following rationale: *“At the present time, for the described medical situation, Official Disability Guidelines would not support this request to be one of medical necessity. This reference would not support this request to be one of medical necessity, as there is no documentation of a compressive lesion upon any of the neural elements in the lumbar spine on a recent radiographic assessment of the lumbar spine. As a result, per criteria set forth by the above-noted reference, medical necessity for this request is not presently established.”*

On July 18, 2011, Dr. evaluated the patient for decreased sensation in L4 and L5 distribution on the medial and dorsal surface of the left foot with decreased sensation in the anterior thigh on the left and exaggerated patellar reflex on the left. Examination showed positive reverse SLR on the left and positive SLR on the left with pain in the back and numbness and achiness into the foot. Dr. assessed severe worsening of low back pain, severe worsening weakness in the left lower extremity; inability to squat on the left leg; numbness and tingling in the medial and dorsal surface of the left foot and weakness and decreased sensation in the anterior thigh. Dr. recommended transforaminal injection at L2-L3 and L4-L5 prior to proceeding to hardware injections.

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

*Injured worker with a long history of LBP s/p L4-5 lumbar fusion surgery approximately 15 years ago with treatment notes indicating chronic LBP associated with lower extremity referral pain and long term findings of sensory changes to the LLE. Documentation reveals multilevel DDD to the lumbar spine per diagnostic studies with reports of nerve root entrapment per CT myelogram in June 2011 not involving the fusion level. There are no recent findings of acute focal neurological deterioration to the LLE in terms of muscle atrophy, myotomal strength loss, nor EMG studies to support acute nerve root entrapment. Documentation supports chronic post surgical pain from laminectomy procedure at the L5-S1 level with no reported trauma to any other lumbar spine level. There are findings of multilevel DDD changes on recent diagnostics. Note on 7-18-11 indicated past use of daily HEP increased his pain, exam reported findings of LLE sensory loss along the anterior thigh and leg with hyper-reflexic left patellar reflex, positive SLR on the left. CT Scan in June 2011 positive for Left L4 nerve root entrapment and left encroachment of the L3 nerve root. Past medications have included use of opioids, neuropathic agents (unable to tolerate side effects). Documentation supports findings of LLE radiculopathy in terms of most recent exam findings in conjunction with recent diagnostic studies of nerve root entrapment/encroachment. Past conservative care has reportedly failed including use of PT/HEP along with opioids/neuropathic agents p.o.*

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT  
GUIDELINES**