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Notice of Independent Review Decision

DATE OF REVIEW: July 5, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right selective epidural at L4-L5

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

Doctor of Chiropractic

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

Review Med:

- Procedure (10/22/09)
- Reviews (08/19/10)
- Diagnostics (09/01/10)
- Office visits (09/21/10 – 12/13/10)
- Utilization reviews (06/14/11 – 06/20/11)

Dr.:

- Procedure (10/22/09)
- Office visits (07/19/10 – 04/29/10)
- Diagnostics (09/01/10)
- Utilization reviews (06/14/11 – 06/20/11)

TDI:

- Utilization reviews (06/14/11 – 06/20/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was lifting and stacking chairs while working at a xxxx on xx/xx/xx, and developed low back pain primarily on the right side.

2009: On October 22, 2009, M.D., performed a transforaminal epidural steroid injection (ESI) at L5 on the right for the diagnosis of lumbar radiculopathy.

2010: On May 28, 2010, M.D., evaluated the patient for left lower extremity pain. He was utilizing hydrocodone, Plavix, HCTZ, simvastatin, Vasotec and Toprol XL. Review of systems was positive for pain in the left lower extremity secondary to prolonged standing. Dr. diagnosed chronic low back pain radiating down the left hip and leg and continued the patient on hydrocodone.

D.C., evaluated the patient for ongoing low back pain and bilateral hip and leg pain, weakness and paraesthesia in the right L5 distribution. The patient was unable to ambulate on his heels and toes. History was positive for hip fracture from an old injury. The patient reported limited range of motion (ROM) and decreased strength in the lower extremities bilaterally. Dr. recommended electromyography/nerve conduction velocity (EMG/NCV), functional capacity evaluation (FCE) and active therapy.

M.D., obtained EMG of the left lower extremity that revealed left lumbar radiculopathy. Dr. recommended diagnostic and therapeutic injections and magnetic resonance imaging (MRI) of the lumbar spine.

On August 19, 2010, D.C., performed a peer review and noted the following treatment history: *Following the injury, the patient was taken to the Hospital for right-sided lower back pain with mild radiating pain into the right leg and chronic left hip pain and left lower extremity pain. The patient was observed ambulating with a slow gait. Lumbar spine x-ray showed a slight decrease in disc space at L3-L4 with mild lumbar spondylosis. The patient was treated with Norflex and Toradol. On May 22, 2009, D.C., performed chiropractic evaluation and noted tenderness at the lumbosacral region, forward flexed antalgic posture, slow getting up from a seated position. Reflexes were 2+ and give way weakness was noted in the left lower extremity, straight leg raise was tight bilaterally with radicular findings on the right at about 50 degrees. Dr. kept him off work. M.D., diagnosed chronic left hip and left knee pain stemming from the fracture in December xxxx. The patient was prescribed medicines and recommended to have therapy with Dr.. On May 26, the patient was released to light duty with restrictions. Dr. obtained MRI of the lumbar spine that showed facet arthropathy at L4-L5 and mild disc desiccation at L5-S1 only with a small right-sided paracentral disc protrusion with minimally right-sided lateral recess narrowing noted at L5-S1 that could be affecting the S1 nerve root on the right. From May through July, the patient underwent 14 therapy visits with Dr..*

Dr. noted that the patient had right-sided complaints as well. The patient continued along with therapy and was noted to ambulate on his heels and toes with no loss of strength. The patient was recommended to continue with his home exercise plan. Dr. opined the patient was not responding favorably to care at that point.

On September 3, 2009, D.C., performed a peer review and opined no more treatment was necessary and recommended tapering off the narcotic medication. There was a reassessment performed by Dr., where he noted limited activities and deep tendon reflexes being mildly reduced on the right and atrophy in the left lower extremity. Dr. performed Beck depression and anxiety tests, both indicating high scores in the severe range.

On October 20, 2009, the patient had ESI with some benefit. On October 29, 2009, the patient was seen by M.D., who assessed maximum medical Improvement (MMI) with 5% whole person impairment (WPI). Dr. noted no relief from the ESI and the patient complained of increased pain following the injection.

On February 15, 2010, the patient was sent to the emergency room by Dr. who apparently was not being paid for his office visits. At the emergency room the patient was prescribed Toradol.

Dr. rendered the following opinions: (1) the supported diagnosis was lumbar strain with disc protrusion at L5-S1. (2) Current signs and symptoms in the lower back and right lower extremity were directly related to the compensable injury. (3) Documentation supported a pre-existing condition concerning the left lower extremity including the hip, knee and leg from a previous accident in December 2004. (4) Current treatment including office visits, diagnostic testing, referrals, PT or surgery was not reasonable. (5) The patient had no improvement from treatment given for the work-related injury. (6) No further manipulations or PT was recommended.

On September 1, 2010, MRI of the lumbar spine showed mild annular disc bulge at L2-L3; a mild diffuse annular bulge at L3-L4 tending to lateralize to the bilateral foraminal region with moderate facet hypertrophy; mild annular disc bulge at L4-L5 with mild facet hypertrophy and mild central disc protrusion at L5-S1 into the posterior epidural fat. Dr. reviewed the MRI and recommended left L4 and L5 transforaminal ESI. Dr. noted that the request for selective epidural in the lumbar spine was denied.

On November 30, 2010, Dr. noted the patient was status post injection under the direction of Dr. with good improvement. Through December, the patient attended six sessions of active therapy under the care of Dr..

2011: In February, Dr. noted ongoing chronic lower extremity and lumbar spine symptoms. He recommended continuing home exercise program (HEP) and opined that the patient had a couple of injections and responded fairly well to that however he continued to aggravate the condition with his continued working.

On April 29, 2011, Dr. noted pain in the lumbar spine radiating into the lower extremities, difficult activities because of the pain, paresthesia and weakness in the lower extremities. Examination showed decreased leg raise on the right, exquisite tenderness of the lumbar spine with palpable muscle spasms. Dr. recommended lumbar extension exercises to help ROM and activity tolerance.

Per utilization review dated June 14, 2011, the request for right selective epidural at L4/L5 was denied by M.D., with the following rationale: *"I spoke with Dr., explained to him that the guidelines required the radiculopathy be documented*

on physical exam and corroborated by imaging studies. There were subjective findings of weakness on exam but no objective findings such as significant atrophy or absent reflex. The MRI does not show any nerve root compression. Therefore the request does not meet guidelines criteria and is not certified. Official Disability Guidelines requires radiculopathy be documented on physical examination and corroborated by imaging studies. The MRI reported no nerve compression and there is no documentation of lower levels of care including NSAIDs or muscle relaxers. Records do not reflect any improvement after the last ESI or a decrease in pain medication.”

Per reconsideration review dated June 20, 2011, the appeal for right selective epidural at L4/L5 was denied by M.D., with following rationale: *“I was able to speak to Dr.. In the course of our conversation, we discussed that he does not perform the epidural and that the claimant has not seen the pain specialist at this time. He was unable to provide additional clinical information to warrant the request. This information did not present additional clinical information to substantiate the requested service.”*

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

The claimant’s original injury involved the right lumbar spine and lumbar spine strain was the accepted diagnosed condition for the xx/xx/xx compensable injury. The claimant appears to have sustained a prior work injury involving the left lower extremity. Imaging studies of the lumbar spine revealed degenerative disc and joint disease in this male. The chiropractor stated in his 12/03/10 report that it was unlikely that the claimant would return to full duty considering his age and body habitus. The claimant’s prior work injury to the left lower extremity was a source of ongoing aggravation based on the report. The claimant anticipated retirement at age 65. In this case, the chiropractor appears confused throughout the records on exactly what the compensable injury is as well as the compensable body part. The compensable injury involved a strain to the right lumbar spinal area. There was no established injury to the right lower extremity or lumbar radiculopathy on the right side. There was no clinical finding or objective finding of radiculopathy to the right lower extremity and the lumbar spine MRI did not document neurocompressive issues to the right side. Therefore, there is no support utilizing ODG treatment guidelines for the requested right sided selective epidural steroid injection at L4 and L5.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**