

# MATUTECH, INC.

PO BOX 310069  
NEW BRAUNFELS, TX 78131  
PHONE: 800-929-9078  
FAX: 800-570-9544

---

## Notice of Independent Review Decision

**Date: October 17, 2012**

**IRO CASE #:**

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

Epidural steroid injection cath/saline T3-T4, T5-T6 (62318, 62281, 62310, 62284 and 99144 and 72275-PNR)

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

Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

**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:**

- Diagnostics (09/18/06 - 01/27/12)
- Procedure (07/20/07)
- Reviews (02/20/08 - 07/23/08)
- Office visit (07/14/09 - 08/07/12)
- Utilization reviews (08/07/12, 09/14/12)

**TDI**

- Utilization reviews (08/07/12, 09/14/12)

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

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained a work-related injury on xx/xx/xx. He was hit by the backhoe bucket of a tractor and was knocked against a power pole. He sustained injury to the neck and upper back.

On September 18, 2006, the patient underwent magnetic resonance imaging (MRI) of the thoracic spine that showed small right paracentral disc protrusion at T6-T7 thinning the anterior subarachnoid space but producing any significant mass effect on the thoracic cord.

On July 20, 2007, M.D., performed placement of Gardner-Wells tongs, anterior cervical discectomy at C5-C6 and C6-C7 using Smith-Robinson technique; anterior cervical fusion with #8 PK cages packed with bone gel at C6-C7 and C5-C6. A plate was strutted from C7 through C5, using a 14 mm screw at C7, C6 and C5. The preoperative diagnosis was herniated disc at C5-C6 and C6-C7.

On January 29, 2008, M.D., performed a designated doctor evaluation (DDE). The chief complaints were neck pain status post fusion. Dr. noted following treatment history: *Following the injury the patient was seen by Dr.. X-rays were done and he was treated conservatively. On August 11, 2005, x-rays of the thoracic spine showed degenerative changes of the thoracic spine. On August 7, 2006, MRI of the lumbar spine showed: At L3-L3, left central extrusion extending inferiorly to the disc space level lying posterior to the superior portion of the virtual body of L4 causing moderate left lateral recess stenosis with suspected compression of the left L4 preganglionic nerve root. Nerve conduction tests were done on September 18, 2006, which showed mild evidence of carpal tunnel and no evidence of radiculopathy. MRI of the cervical spine on October 30, 2006, showed multilevel disc protrusion with severe spinal stenosis at C5-C6 with flattening of the underlying cord and bilateral neural foraminal stenosis and moderate disc protrusion at C3-C4, C5-C6 with severe left paracentral C6-C7 and moderate right C7-T1 disc protrusion. The patient was then seen by Dr. on October 10, 2006, who suggested that the patient was not at maximum medical improvement (MMI) and would probably need treatment for the neck. The patient was treated with epidural steroid injection (ESI) in the cervical spine by the treating doctor. The patient was then seen by a designated doctor, Dr. on March 13, 2007, who recommended that the patient was not at MMI and that his prospective MMI date would be September 13, 2007. Dr. assessed clinical MMI as of January 29, 2008, and assigned 25% whole person impairment (WPI) rating. Dr. noted that the patient underwent a functional capacity evaluation (FCE) that showed he could safely perform at medium physical demand level (PDL).*

On July 23, 2008, M.D., performed a required medical evaluation (RME) and opined as follows: (1) The patient had significant spinal stenosis in the neck prior to the accident. (2) The patient was hit by the backhoe and most likely went through the disc and ruptured the disc in his thoracic spine. (3) The primary

problem was a contusion to the spinal cord. (4) The patient was still having long-tract findings on the physical examination. (5) The patient suffered damage or harm to the physical structure of his body and had an unstable spine. (6) Dr. used the appropriate scale in assessing the patient. The opinion by Dr. was reasonable and accurate and related to the injury of August 10, 2005. (7) The limitation of injury to the cervical spine at C5-C7 and the thoracic spine at T6-T7 was reasonable based on the history obtained from the patient, the exam and review of records. (8) Follow-up with Dr. was reasonable and necessary from three to six months or p.r.n. The Lyrica and Tylenol #3 should be relatively tolerated. The patient could be on those medications life-long. Any further surgery or further injections would not be recommended. Periodic evaluation by Dr. for medications and long-term work restrictions was reasonable.

On July 14, 2009, Dr. M.D., noted the pattern of symptoms was essentially unchanged. The patient had not been working because no light duty was available. He noted some relief of symptoms with medications. His gait was halting and antalgic. Dr. assessed back pain and cervicalgia, recommended completing physiatric treatment and continuing medications.

On August 28, 2009, Dr. noted the patient had been working within the duty restrictions and was tolerating the job well. The patient felt that the pattern of symptoms was improving. Dr. Siemens referred the patient to Dr. for further treatment and evaluation.

On October 15, 2009, C. M.D., evaluated the patient for neck pain which was minimal. The patient was back at work full-time with no restrictions and was doing well. Dr. recommended continuing conservative management. He felt that the patient would be a candidate for an ESI versus facet injections.

From 2009 through 2010, no records are available.

On March 4, 2011, Dr. noted that the pattern of symptoms was slowly worsening. The patient had been working within the duty restrictions and had not been taking his medications. The patient was referred to a local physiatrist. The patient informed that he had not seen that physiatrist. Dr. assessed back pain and transferred the patient's care to a physiatrist for further treatment.

In April, Dr. evaluated the patient for thoracic pain that had begun a few weeks ago. Examination of the thoracic spine showed significant pain at approximately T7-T8 distribution especially over the spinous and paraspinous regions worse with twisting. The patient had some lower extremity tenderness over the spinous and paraspinous regions with absence of lower extremity radiculopathy. Dr. assessed stable neck pain, severe mid-thoracic pain and low back pain. He prescribed Norco, Skelaxin and Naprelan; ordered MRI of the cervical, thoracic and lumbar spine and recommended continuing conservative modalities including physical therapy (PT) and medications. He opined that the patient was a candidate for an

LSF back brace as well as transcutaneous electrical nerve stimulation (TENS) unit. He recommended bilateral thoracic facet injection for pain.

On April 8, 2011, urine drug screen was positive for a marijuana metabolite THCA (IA).

On April 21, 2011, MRI of the thoracic spine showed minimal disc bulges at T3-T4, T5-T6 and T6-T7.

In May, Dr. noted pain in the cervical and thoracic spine radiating primarily on the right side causing spasms in the cervical and thoracic region. The pain was in the cervicothoracic region and it was severe excruciating and intractable. He reviewed the MRI findings and recommended proceeding with facet injections in the cervical and thoracic spine. He also recommended continuing medications and conservative modalities.

**2012:** On January 23, 2012, the patient reported continued pain in the cervical and thoracic spine. Dr. noted that the conservative modalities including PT and medications had exhausted. The overall pain was getting progressively worse. Dr. assessed neck pain with upper extremity radiculopathy which was getting progressively worse with new onset of numbness to the hands bilaterally which was getting progressively worse and there was weakness in the upper extremity. Dr. prescribed Skelaxin and recommended ESI in the cervical spine and continuing conservative modalities including PT and medications.

On January 23, 2012, urine drug screen was positive for opiates, hydrocodone, hydromorphone, marijuana, cotinine and acetaminophen.

On January 31, 2012, Dr. assessed thoracic pain with involvement of pain extending into the thoracic region as well as extending into the cervical region and cervical spine pain secondary to disc pathology. He recommended proceeding with ESI in the cervical spine as all other conservative modalities had failed.

On August 1, 2012, the patient reported continued complaints of pain in the thoracic spine which had become progressively worse. He also complained of neck pain but currently the thoracic pain was the worst pain. Examination revealed tenderness in the cervical and thoracic spine and a very little low back pain with lower extremity radiculopathy. The most symptomatic region was in the thoracic spine as well as the cervical spine. There were some limitations in ROM and also some tenderness over the spinous and paraspinous regions. Straight leg raise (SLR) was to 30 degrees with pain and there was some radicular pain extending to the lower extremities. Dr. recommended thoracic ESI at the T3-T4 and T5-T6 and continuing medications as well as PT. He opined that the patient had continued with PT at home and had exhausted all conservative modalities.

Per utilization review dated August 7, 2012, the request for thoracic ESI Cath/Saline T3-T4 and T5-T6 was denied based on the following rationale: *"The*

*patient is a male whose date of injury is xx/xx/xx, when he was struck by the bucket of a backhoe, injuring his upper and mid-back and neck area. He is status post ACDF C5-C6, C6-C7 on July 20, 2007. The patient was seen on August 1, 2012 with complaints of pain in the thoracic spine which has become progressively worse. He also complains of neck pain. MRI of the thoracic spine dated April 21, 2011, revealed minimal disc bulges at T3-T4, T5-T6, T6-T7 without cord contact; there is no syrinx or myelomalacia; there is normal CSF dorsal to the cord at all levels. Examination reported the patient to weigh 230 pounds, and height is 6'1". There is tenderness to palpation in the thoracic and cervical spine primarily and very little low back pain with lower extremity radiculopathy. There are some limitations in range of motion and also some tenderness to palpation over the spinous and paraspinous regions. There is no muscle wasting; DTRs remain hyperreflexic. Straight leg raise is to 30 degrees with pain and there is some radicular pain extending to the lower extremities. There is no documentation of treatment to date for the thoracic spine. Noting that MRI showed minimal disc bulges with no evidence of neurocompressive pathology, and noting that there is no evidence of motor or sensory changes, the proposed thoracic epidural steroid injection is not recommended as medically necessary."*

On August 7, 2012, Dr. evaluated the patient for significant disc pathology demonstrating involvement of the thoracic spine specifically bulging at T3-T4, T5-T6 and C6-C7. He opined that all the conservative modalities had exhausted and the recommendation was bilateral cervical facet injections.

In a letter dated August 29, 2012, Dr. opined that the patient had significant disc pathology in the thoracic spine that was demonstrated by MRI specifically bulging discs at T3-T4, T5-T6 and T6-T7. The patient had not undergone any interventional procedure that was necessary.

Per the reconsideration review dated September 14, 2012, the appeal for ESI Cath/Saline T3-T4 and T5-T6 was denied based on the following rationale: *"The patient was injured on xx/xx/xx and underwent anterior cervical discectomy and fusion at C5-C6 and C6-C7 on July 20, 2007. As per office visit dated August 1, 2012, he presented with persistent and worsening thoracic spine pain that radiates to the anterior chest wall region. Upper extremity numbness and weakness were also reported. Physical examination revealed tenderness over the spinous and paraspinous regions and restricted range of motion. Hyperreflexic reflexes and positive straight leg raise test with associated radicular pain in the lower extremities were also appreciated. A plan to continue with medications and physical therapy was indicated. This is an appeal request for the medical necessity of ASC thoracic ESI with catheter and saline at the T3-T4 and T5-T6 levels 62318, 62281, 62310, 62284 (99144, 72275-PNR). The previous request was non-certified because treatment rendered to date for the thoracic spine was not documented. Non-certification was also given because MRI showed minimal disc bulges with no evidence of neurocompressive pathology and the clinical exam noted no evidence of motor or sensory changes. Updated documentation submitted for this appeal includes progress notes which indicate*

*previous employment of active therapy modalities for the thoracic area. However, the latest physical examination still did not document motor and sensory deficits in specific distributions to clinically demonstrate radiculopathy, particularly at the planned injection levels. Likewise, the latest thoracic MRI provided still did not exhibit nerve root impingement, significant stenosis and/or other objective findings that may corroborate radiculopathy. Moreover, a clear rationale for the need for sedation was not specified. A plan to perform the procedure using fluoroscopy (live x-ray) was also not reported. Based on these grounds, the medical necessity of this request is not substantiated, and the previous non-certification is upheld.”*

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

The patient was injured on xx/xx/xx. The office visit on August 1, 2012 reports worsening thoracic pain that radiated to the anterior chest wall. The physical exam revealed tenderness in the spinous and paraspinal regions with restricted range of motion. Straight leg raise was noted to be positive causing associated radicular symptoms in the lower extremities. MRI of the thoracic spine dated April 21, 2011 reports minimal disc bulges at T3-4, T5-6, T6-7 without cord contact. The patient has attempted conservative treatment. There is no clear neurocompressive lesion on MRI, no electrodiagnostic study and insufficient physical exam findings to support the request. Based on these grounds, the medical necessity of this request is not substantiated.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**