



IMED, INC.

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 04/07/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Item in dispute: Repeat MRI of the lumbar spine

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Employer's First Report of Injury or Illness dated xx/xx/xx.
2. M.D., dated 01/02/05 thru 02/06/05.
3. MRI of the lumbar spine dated 01/10/05.
4. D.C., dated 01/19/05 thru 02/01/05.
5. Medical records from Dr. dated 02/09/05 thru 10/05/06.
6. EMG/NCV study dated 02/16/05.
7. Medical records from Dr. dated 07/08/05 thru 08/24/05.
8. Medical records from Clinic dated 07/11/05 thru 10/18/05.
9. Psychiatric evaluation dated 08/31/05.
10. Medical records from Dr. dated 12/07/06 thru 02/13/08.
11. Designated Doctor Evaluation, Dr., dated 07/11/07.
12. Medical records from Dr. dated 07/11/07.
13. Required Medical Evaluation from Dr. dated 11/09/07.
14. Letter of appeal, Mr. undated.

15. Utilization review determination dated 02/21/08.

16. Utilization review determination dated 03/03/08.

17. Official Disability Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee is a xx year old male who was reported to have sustained an injury to his low back on xx/xx/xx while lifting some marine batteries. The employee developed pain in his low back. Extensive clinical records were submitted. There are approximately 300 pages of correspondence. The chart was reviewed and pertinent records were reviewed.

The records indicate that the employee underwent an MRI of the lumbar spine on 01/10/05. This study was compared against a prior MRI dated 10/12/04. This study reported a broad-based central/right paracentral disc protrusion at the L5-S1 level which was stable when compared to the prior study. The traversing right S1 nerve root sheath was deflected. Proximal narrowing of the right exit neural foramen was also noted. Posterior facet arthrosis was moderate at this level and was also stable since the prior study. There was a shallow left paracentral disc protrusion at L4-L5 noted in retrospect on the prior MRI. This was not significantly changed in size or appearance. There was no canal or foraminal stenosis.

The employee underwent EMG/NCV studies on 02/16/05. A review of the EMG report indicated no evidence of a lower extremity radiculopathy.

Records indicated that the employee received extensive treatment while residing in, Texas, which included treatment at the Clinic and treatment by pain management physician, Dr. The employee was also treated by Dr..

The employee subsequently moved to the area, and on 01/09/06, the employee came under the care of Dr.. Dr. reported that the employee suffered a forward flexing twisting type maneuver. The employee was on multiple medications. Dr. noted that Dr. performed epidural steroid injections which provided temporary relief, and he was evaluated by Dr. who felt that the employee was not a spinal candidate. Dr. noted that Dr. reported multiple Waddell signs. At the time of this evaluation, the employee clearly showed signs of emotional distress. Upon physical examination, the employee was 5 feet 9 inches in height and weighed 120 pounds. Reflexes were non-pathologic. Motor and sensory examinations were without deficit. There was diffuse tenderness over the lumbar paraspinal segments, and there was tenderness over the L4-L5 and L5-S1 facet joints which is somewhat worse with hyperextension and lateral bending. The employee was diagnosed with mechanical low back pain, possible facet arthropathy, and possible discopathy.

The employee was later seen by a designated doctor on 07/11/07. Dr. found that the employee sustained a lumbar strain as a result of his workplace event. Upon examination, the employee had complaints of pain in the lumbar spine, mid

back, left leg, and left foot accompanied by numbness and weakness in the lumbar spine and the left leg. The employee was noted to be 5 feet 7 inches in height and weighed 120 pounds. He was well-developed and well-nourished. He was cooperative. The employee ambulated into the examination room with a normal gait and did not utilize any assistive devices. Kernig and Brudzinski tests were negative bilaterally. Straight leg raising was 30 degrees on the left and 50 degrees on the right. Sitting root test was negative bilaterally. Patrick Faber's test was negative bilaterally. Range of motion of the lumbar spine was performed without effort. Sensation in the lower extremities was intact. Deep tendon reflexes were 2 and symmetric. The employee was able to heel toe walk without difficulty. Dr. found that the employee was at clinical Maximum Medical Improvement (MMI) and assessed a 0% whole person impairment for the diagnosis of a lumbar strain.

On 07/11/07, the employee was evaluated by Dr.. The employee again reported low back pain with radiation into the left lower extremity. The employee was reported to have undergone extensive active and passive physical therapy and chiropractic manipulations. The employee was seen by Dr. and reportedly diagnosed with fibromyalgia, mechanical back pain and sciatica. The employee showed signs of distress and anxiety and was referred to a psychiatrist who placed him on Celexa for depression and anxiety. Dr. reported plain films dated 07/05/07 revealed evidence of a retrolisthesis of L5 on S1 and a probable unilateral pars defect on the left. The employee has undergone translumbar epidural steroid injections x 4 performed by Dr.. Upon physical examination, the employee had reduced lumbar range of motion. He had intact deep tendon reflexes. Straight leg raising was reported to be positive bilaterally, left greater than right. He had a positive Lasegue's on the left. He had 3/5 weakness of dorsal eversion of the left foot and 3/5 weakness in the left EHL. His feet were symmetrically cool. He had some numbness in the left proximal distal anterior thigh in an L2-L4 distribution and to the left lower leg and ankle in an L5-S1 distribution. The employee was diagnosed with spondylosis and disc protrusions at L4-L5 and L5-S1, instability with retrolisthesis of L5 on S1, and chronic lumbar radicular syndrome. Dr. recommended that the employee undergo discography. The employee was later seen for a Required Medical Evaluation (RME) performed by Dr. on 11/09/07. Dr. reported that the employee was currently on multiple medications and was being followed by Dr.. Dr. reported the history of injury. He subsequently indicated that that injury resolved after about a week and the employee returned to work after one to two weeks. The employee was doing well until 12/23/04. Dr. noted that the only thing that occurred between 02/27/03 and 12/23/04 was that the employee had kidney stones and sought medical management for that personal condition. The employee reported that on 12/23/04 he was again carrying batteries and developed low back pain. Upon physical examination, Dr. reported multiple Waddell signs. He noted that the employee had tenderness to light palpation over the entire lumbosacral area and tenderness to deep palpation and lumbar range of motion was reduced. All movements elicited complaints of low back pain. Dr. noted that the employee was observed sitting comfortably in a chair which implied a lumbosacral angle of

about 90 degrees. He reported that straight leg raising was negative at 90 degrees on the right and positive at 90 degrees on the left with worsening of sciatica. However, when this was done in the laying position, straight leg raising on the right remained negative. However, on the right it became positive at only 30 degrees. He noted there was a discrepancy between seated straight leg raising. He noted give-way weakness in all of the major muscle groups in the left lower extremity with similar findings on the right. Sensory examination was described as stocking glove, and he noted the employee had over exaggerated behaviors. He noted no evidence of atrophy. Dr. expressed concern over the employee's use of opioids. He notes that the mechanism of injury was not consistent with the degree of dysfunction that the employee presented with. Dr. recommended against further spinal interventions including injections, and surgery was not a consideration.

The employee was seen in follow-up on 02/13/08. At that time, Dr. opined that the employee was a surgical candidate for a two level 360 degree fusion and noted that the employee's last MRI was dated 01/10/05, and he requested a repeat study.

The records further included a thirteen page letter from the employee explaining his medical history and frustration with workers' compensation system.

On 02/21/08, Dr. recommended an adverse determination on the request for repeat MRI of the lumbar spine. She noted that the employee had positive Waddell signs, disproportionate pain behaviors, and multiple claims. Dr. further noted the designated doctor report and RME and opined that a repeat MRI was duplicative and not medically necessary.

On 03/03/08, Dr. reported an adverse determination against the request for repeat MRI of the lumbar spine. He noted that the initial Designated Doctor Evaluation deemed the claimant to be at MMI, found no neurologic deficits to warrant further surgery, and awarded a 0% whole person impairment. A subsequent RME documented that all Waddell signs were positive for nonphysiologic symptoms and forecasted a poor outcome.

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

I would concur with the two previous reviewers that MRI of the lumbar spine is not indicated or supported by current evidence-based guidelines. In the course of the employee's treatment, the employee has received two MRIs of the lumbar spine which note a very minor disc protrusion at L4-L5 and disc desiccation with protrusion at L5-S1 with some evidence of neural foraminal stenosis. The employee has multiple complaints that are not validated on independent review and examinations. The employee has been evaluated by a designated doctor, who did not find any evidence of neurologic compromise involving the lower

extremities and assessed the employee at a 0% impairment. I would note that the employee had a normal examination on 07/11/07, and on that same day, he was evaluated by Dr. who reported multiple findings. These findings are inconsistent with previous physical examinations by independent examiners. Based on the examinations by Dr. and Dr., the employee has no evidence of a neurologic deficit or in particular a progressive neurologic deficit that would warrant a repeat MRI of the lumbar spine.

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

1. The ***Official Disability Guidelines***, 11th edition, The Work Loss Data Institute.
2. The ***American College of Occupational and Environmental Medicine Guidelines***; Chapter 12.