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Notice of Independent Review Decision

DATE OF REVIEW: 03/20/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Item in dispute: 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. UR report dated 02/08/08.
2. UR report dated 02/22/08.
3. EMG/NCV report dated 04/05/00.
4. Medical records of Dr. dated 04/05/00 thru 01/15/08.
5. CT of the lumbar spine dated 09/26/97.
6. MRI of the lumbar spine dated 04/07/00.
7. CT/myelogram of the lumbar spine dated 05/10/00.
8. Radiographic report of the lumbar dated 11/20/00.
9. Radiographic report of the lumbar dated 07/10/01.
10. MRI of the lumbar spine dated 07/17/01.
11. Medical records of Dr. dated 09/24/01.
12. MRI of the lumbar spine dated 04/15/03.
13. MRI of the lumbar spine dated 12/20/04.
14. CT of the lumbar spine dated 08/22/05.
15. MRI of the lumbar spine dated 01/30/07.
16. ***Official Disability Guidelines.***

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee was xx years old when he was reported to have an injury to his low back as a result of workplace activity on xx/xx/xx.

The employee was subsequently taken to surgery by Dr. on 09/18/00. He underwent decompression lumbar laminectomy of L2, L3, L4, L5, and partial of L1 performed for spinal stenosis. The worst compression was at L4. Postoperatively, the employee was discharged on 09/26/00.

Serial postoperative notes indicate that the employee complained of leg cramping with walking. Serial imaging indicates excellent decompression.

The employee was referred for MRI of the lumbar spine on 07/17/01. This study reported extensive postoperative changes without evidence of recurrent disc herniation or postoperative complications. There was mild to moderate multilevel degenerative disc disease. There was no abnormal contrast enhancement. A clinical note dated 09/24/01 indicated that preoperatively the employee had severe back pain and bilateral leg pain which was improved with surgery. His main complaint was now of cramps in the gastrocs when he tried walking very far. He reported this to be about one block. He complained of leg swelling and was told several years ago by Dr. that he had incompetent veins in his lower extremities. He was further reported to have undergone a recent heart study which was abnormal, and the employee was scheduled for cardiac catheterization.

The employee underwent a repeat MRI of the lumbar spine on 04/15/03. This study reported bilateral laminectomy defects extending from L1-L2 through L5-S1. There was no definite evidence of recurrent disc herniation or significant postoperative complication. There was no abnormal contrast enhancement or epidural scarring. There was no significant intradural findings. There was relatively mild multilevel disc desiccation and degeneration.

The employee had continued complaints and was again referred for an MRI of the lumbar spine on 12/20/04. This study reported evidence of degenerative disease and previous laminectomies. There were no significant disc protrusions noted.

On 08/09/05, the employee was seen in follow-up. He reported intermittent left leg pain down to the knee with back pain. Upon examination, the employee had excellent strength in the quadriceps and extensors. Sitting root test was normal. The employee was referred for CT of the lumbar spine on 08/22/05. This apparently was post discography. This study reported contrast demonstrated in the disc space along the right side of the vertebral disc at L3-L4. There was bilateral posterior facet hypertrophy and a smaller posterior disc bulge with probable mild right sided neural foraminal stenosis. A laminectomy defect was demonstrated. At L4-L5, contrast was demonstrated in the disc space. There

was posterior disc bulge, bilateral posterior facet hypertrophy, and ligamentum flavum hypertrophy. There was mild right neural foraminal stenosis and a mild left neural foraminal stenosis. There was laminectomy defect. At L5-S1, there was a laminectomy defect. There was almost complete loss of disc space height posteriorly. There was posterior disc herniation which contrast demonstrated extending approximately 5 mm posterior into the spinal canal. The neural foramina were narrowed bilaterally, left greater than right.

A follow-up note dated 09/02/05 reported that the employee had a markedly positive discogram at L5-S1. He was subsequently recommended to undergo discectomy and fusion via anterior approach.

The employee was seen in follow-up on 01/16/07. He reported he had been doing fairly well until last Wednesday when he developed sudden onset of low back pain while playing with a computer mouse. Upon examination, there was severe spasm bilaterally. Sitting root test was limited bilaterally. There was mild dorsiflexors weakness. Reflexes were generally hyporeflexic. The employee was provided oral medications and recommended to have MRI.

The employee underwent an MRI on 01/30/07. This study reported postoperative changes at L2-L3 through L4-L5 without evidence of recurrent disc herniation. There was early degenerative disc disease without compressive disc pathology at L5-S1.

The employee was seen in follow-up on 01/15/08. He was reported to have a markedly positive straight leg raise on the left with cross reference from right to left on sitting root testing on the right side. He was reported to have a marked increase in symptomatology, and further studies were warranted including MRI.

On 02/08/08, a request for a lumbar MRI was found not to be medically necessary by Dr.. Dr. opined that there was insufficient evidence of a progressive neurologic deficit. The case was discussed with Dr. nurse.

A second request was submitted on 02/22/08. At that time, Dr. recommended against certification. He reported that it was unclear if this employee underwent fusion surgery in early 2007, and further that the prior imaging was not submitted for review. He noted that this employee, who was recommended for surgery, had not been followed for approximately one year and noted there was no progression of neurologic deficits.

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 supported by the submitted medical documentation. The available medical records indicate that the employee is status post extensive decompression for

spinal stenosis from L2 through S1. The employee's symptoms have waxed and waned in the postoperative period. The records suggest that the employee was considered for fusion after positive discography; however, there is no indication from the records if this surgery was performed.

There was a one year gap in the records, and the employee was most recently seen on 01/15/08. In this very brief note Dr. reported that the employee had a markedly positive straight leg raise on the left side with cross reference from right to left on sitting root testing on the right side. These reported findings are similar to the findings of a clinic note dated 01/30/07 in which Dr. was considering operative intervention. The employee had an MRI at that time that found no acute pathology.

In the absence of a more definitive physical examination and serial notes which clearly indicate a progression of a neurologic deficit, there would be no indication for 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*, Work Loss Edition