

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/17/2009

**IRO CASE #:**

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

Repeat MRI of the lumbar spine (72148)

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

M.D. Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 5/15/09, 6/18/09

Untitled Office Note – phone correspondence -- 10/13/99

Untitled Office Record – : 06/26/00

Surgical Short Stay Record; Lumbar Spine x-rays from OR; Surgical Pathology report: 03/20/01

Dr. – Additional Office Records: 09/12/03;

Physical Therapy Records: 04/04/02; 04/09/02; 04/11/02; 04/16/02; 05/03/02; 05/08/02; 05/11/02; 05/14/02; 05/16/02

Dr. Office Records: 07/07/03; 07/19/04

Dr. – Additional Office Records: 01/26/04; 02/24/04; 11/11/04

Operative Report – Lumbar ESIs & Short Stay form: 05/04/04; 11/16/04; 04/19/05; 08/26/05; 12/27/05; 01/10/06

Dr. (pain mgmt.) Office Records: 02/28/05; 11/10/05; 06/08/06

Dr. Office Records: 12/09/05; 07/11/06

Dr. – Additional Office Records: 09/14/06; 08/20/07

Dr. Additional Office Records: 03/27/07; 09/18/07; 01/07/08

**PATIENT CLINICAL HISTORY SUMMARY**

This male sustained a lifting injury to his low back on xx/xx/xx and was diagnosed initially

with low back strain/sprain, pre-existing lumbar disc degeneration and spondylosis with a prior history of L4-5 lumbar laminectomy. The claimant subsequently underwent an L1-2 right laminotomy/foraminotomy with microdissection and a re-do left L4-5 microdiscectomy with microdissection on 03/20/01. The 06/07/01 documentation revealed the claimant was released from postop care and allowed to resume full duty work status.

Later office records dated 02/13/02 revealed complaints of continued left buttock and hip pain not improved since surgery. Additional diagnostic testing was completed including a lumbar myelogram and post CT scan on 03/27/02, an EMG/NC study completed on 10/02/03 and a repeat lumbar MRI done 10/20/03. All revealed chronic and postop changes with no evidence of acute radiculopathy or recurrent disc. The claimant was referred for pain management on 12/04/03 for additional treatment. Documented conservative treatment to this point had included medications, aquatic therapy, traction, home exercise and physical therapy. The claimant underwent at least 6 lumbar epidural steroid injections from 05/04/04 through 01/10/06 under the care of Dr. and Dr.

An updated lumbar MRI dated 06/29/06 revealed diffuse disc bulges at L3-4 through L5-S1 with mild bilateral neural foraminal stenosis at L3-4 and L4-5. Dr. was consulted on 09/26/06 to evaluate and treat the claimant's ongoing low back pain that radiated into his bilateral lower extremities. The claimant was diagnosed with lumbar disc displacement, lumbar spondylosis and postlaminectomy syndrome. He underwent additional lumbar epidural steroid injections from 10/09/06 through 02/10/09 with approximately 3 to 4 months of symptom relief obtained.

A neurosurgical evaluation was completed by Dr. on 06/01/09 with exam findings of tenderness to palpation over the paraspinal muscles of L5-S1 and sacroiliac joints noted to be greatest on the right with numbness along his bilateral anterolateral thighs as well as quadriceps and hamstring weakness bilaterally that was greatest on the right. Dr. documented findings from lumbar x-rays that revealed disc space narrowing from L3-4 through L5-S1 that was worse at L4-5 and significant facet joint degenerative changes and hypertrophy. Dr. noted a lumbar MRI dated 04/18/08 revealed multilevel lumbar degenerative disc disease, bilateral lateral recess spinal stenosis and right sided L4-5 lateral recess stenosis with collapsed disc over L3-4 and L4-5.

The claimant reported ongoing symptoms that were managed with lumbar epidural steroid injections that were currently not as effective as they had been in the past, now lasting only 1 to 2 months before pain returned. Dr. requested authorization for an updated lumbar MRI in anticipation and preparation of a planned decompression laminectomy and fusion of L3-4 and L4-5.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The evidence based literature suggests that imaging studies such as an MRI scan can be recommended for individuals who have progressive neurologic deficit, signs of a neural compressive lesion, and/or back pain of an ongoing nature for which a diagnosis cannot be made based on plain radiographs and/or an individual has failed conservative care.

The records document a preoperative MRI scan in 2000 and a postoperative CT myelogram in 03/27/02, and postoperative MRI scans of 10/20/03, 11/16/05, and 06/29/06. The most recent MRI scan was from 04/18/08 which showed a combination of degenerative changes and varying degrees of disc pathology. On no occasion following the MRI scan has there been anything recommended other than continuation of conservative care either in the form of medical management and/or epidural steroid injections. It appears as though this individual has had a multitude of epidural steroid injections. According to the most recent notes, there has been a progressive change, but the change appears to be nothing other than increasing back pain.

There is no compelling indication that further imaging studies are likely to show any meaningful change over those that have been documented postoperatively to date. There is no objective change in imaging studies and no true objective findings on examination that would show progressive changes from those that have been previously documented. A number of injections have been done in the past that do not appear to have resulted in substantial long term clinical improvement. Based on the information provided the request cannot be considered reasonable and/or medically necessary in this setting as the additional imaging study is unlikely to offer additional information that has not been previously documented on MRI. If there were a true objective change in one's clinical examination, whether they be structural changes on plain radiographs and/or progressive objective findings on exam then additional imaging studies would certainly be warranted in that setting. This is not the case with this particular patient, and therefore the request does not meet the ODG criteria. The reviewer finds that medical necessity does not exist for Repeat MRI of the lumbar spine (72148).

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates: low back

ODG guidelines -- MRI's (magnetic resonance imaging)

- Recommended for indications below.
- Repeat MRI's are indicated only if there has been progression of neurologic deficit

Indications for imaging -- Magnetic resonance imaging

- Thoracic and/or Lumbar spine trauma: with neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit
- Uncomplicated low back pain, suspicion of cancer, infection
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit
- Uncomplicated low back pain, prior lumbar surgery and/or cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful; sudden onset; stepwise progressive and/or slowly progressive
- Myelopathy, infectious disease patient or oncology patient

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH

**ACCEPTED MEDICAL STANDARDS**

**MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**MILLIMAN CARE GUIDELINES**

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

**PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

**TEXAS TACADA GUIDELINES**

**TMF SCREENING CRITERIA MANUAL**

**PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**