



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 01/02/09

**IRO CASE #:**

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

The services under dispute include an MRI of the lumbar spine, bilateral NCV of the lower extremities and physical therapy times 10 sessions.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation and also in Electrodiagnostic Medicine. This reviewer has been practicing for greater than 10 years.

**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)

The reviewer disagrees with the previous determination regarding all services under review.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Dr. and Mgmt.

These records consist of the following (duplicate records are only listed from one source): Dr.: progress notes by Dr. from 7/16/07 to 11/4/08, 5 view lumbar x-ray report of 5-14-08, 2-7-03 radiology report and 3/10/03 lumbar MRI report.

14 exhibits consisting of the following: 12/16/08 letter, MD, 11/14/08 denial letter, 11/12/08 email from, 11/12/08 email from, preauth requests undated, 12/2/08 denial letter, 12/1/08 email from, 9/18/03 neurodiagnostic testing, 9/18/03 letter from, MD, E1 report, new TWCC # letter, Initial Med report of xx/xx/xx, notes by,

DC of 2/7/03, medical release of 2/7/03, various TWCC 73's, TWCC 64 3/13/03 to 6/13/03, progress notes of 2/7/03 to 8/07/03, 3/20/03 note by, MD, 4/3/03 to 5/20/03 operative reports, notes by Dr. of 4/28/03 to 8/22/03, 5/6/03 letter by post op monitoring note 5/19/03, preop assessment 5/20/03, rhythm strips of 5/19/03, psychological notes 6/30/03, 6/4/03 FCE, 7/3/03 Interdisciplinary staff rx plan, RTW daily notes 6/30/03 to 7/4/03, TWCC 21 8/8/03, 7/2/03 RTW eval by City of and 10/3/03 report by, DC.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured while falling into a ditch during the course of his job duties. He was previously managed with facet blocks and percutaneous rhizotomy as well as PT in 2003. On 5/8/08, Dr. states, "the patient was alright until 1 month ago when the pain in his low back got worse.

The examination reveals the following: "range of motion is moderately restricted in all ROM's due to pain. Tenderness is moderate, bilateral in the paravertebral, facet joint, PSIS, SI joint and ilio-lumbar areas. Muscle spasm is moderate in the same general areas. SLR was not able to be performed secondary to pain."

The most recent documentation of a physical examination is in June of 2003 by Dr. who indicated, "ROM is improved...marked tenderness to bilateral paralumbar area and bilateral sacroiliac areas.

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

The indications for MRI as per the ODG are as follows:

- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, 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. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.)
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient

- Myelopathy, oncology patient

The most recent MRI in March of 2003 revealed L5/S1 spondylosis, facet arthrosis, and broad based subligamentar posterior disc herniation and L4/5 foraminal stenosis and facet arthrosis. The clinical examination on 5/1/08 shows clinical deterioration of the patient; therefore, this MRI is medically necessary according to the records provided.

Regarding the electrodiagnostic testing, it revealed (9/18/03) S1 radiculopathy bilaterally which correlated to the findings of the MRI. However, a full and complete examination by Dr. could not be performed secondary to pain as documented in the notes.

The ODG recommends an NCV as follows: Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. EMG's may be required by the AMA Guides for an impairment rating of radiculopathy.

Again, pathology was previously verified and correlated to the findings of the MRI. The clinical examination was limited by pain. Therefore, the ODG allows for the neurodiagnostic testing because the pain generator is not clinically obvious.

Regarding the PT, the ODG notes: Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial".

**Lumbar sprains and strains (ICD9 847.2):**

10 visits over 8 weeks

**Lumbago; Backache, unspecified (ICD9 724.2; 724.5):**

9 visits over 8 weeks

**Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):**

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

The current exacerbation of this injury qualifies for the requested PT as per the ODG guides. Therefore, the requested services are medically necessary.

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

- ACOEM- AMERICAN 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)