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Notice of Independent Review Decision

DATE OF REVIEW: MAY 26, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRI lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Utilization reviews (04/10/09, 04/30/09)
- Office visits (12/16/08 – 04/02/09)
- Diagnostics (10/14/08, 10/20/08)

Clinic:
- Office visits (10/03/00 – 04/02/09)
- Diagnostics (10/14/08, 10/20/08)
- Procedures (08/06/08 – 09/02/08)
- Reviews (02/14/04)

TDI:
- Utilization reviews (04/10/09, 04/30/09)

ODG criteria has been used for denials

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient, a female who injured herself on xx/xx/xx. Mechanism of injury is not available.

2000: On January 14, 2000, M.D., an orthopedic surgeon, conducted a medical examination and noted pain in the patient's head, neck, shoulders, arms, waist, and left foot. He assessed maximum medical improvement (MMI) with 4% whole person impairment (WPI) rating. M.D., diagnosed the patient with herniated nucleus pulposus at C5-C6 and C6-C7 to the left. On March 10, 2000, M.D., certified that the examinee had not reached MMI. M.D., noted full range of motion (ROM) of neck and shoulder with pain in the cervical spine from C2-C6 and greater occipital nerve, but no evidence of spasm.

On October 3, 2000, Dr. conducted another medical evaluation and noted the patient had received additional medications, pain management program, epidural steroid injections (ESI), and trigger point injections (TPI). The ongoing treatment included muscle stimulation and medications consisting of Ultram, Celebrex, and Parafon Forte. Magnetic resonance imaging (MRI) of the cervical spine showed: Disc bulging at C4-C5, C5-C6, and C6-C7 with some straightening of cervical lordosis. At C5-C6 bulging was to the left. Similar type of bulge was noted at C6-C7 and a broad based disc bulge at C4-C5. Examination revealed tenderness over the left suprascapular region, left buttock, spinous processes from C1-C7 and S2 area, and anterolateral area of the left foot, limited lumbar ROM, and tenderness on Waddell's test. Dr. assessed resolving cervical and lumbar strain, suboccipital neuralgia, and improving left foot pain of indefinite etiology. He opined that the patient was not a surgical candidate and had reached MMI.

2004: On February 14, 2004, M.D., in an impairment rating review, disagreed with the 29% WPI assigned by Dr. and stated that the impairment rating should not be more than 10% WPI.

2008: On June 23, 2008, M.D., noted continued neck pain radiating to both arms with numbness and weakness and a pain intensity level of 8/10. Examination of the cervical spine revealed increased cervical lordosis, painful restricted ROM, moderate tenderness and muscular spasms in the paravertebral area, facet joint, trapezius, and scapulocostal areas with associated myofascial trigger points. Examination of the lumbar spine revealed posture exaggerated lumbar lordosis, moderately restricted ROM, moderate tenderness and muscle spasms over paravertebral, facet joint, posterosuperior iliac spine (PSIS), sacroiliac (SI) joint, infra-gluteal area, iliolumbar, sciatic notch bilaterally and over vertebral spinous process. Dr. assessed lumbar and cervical facet dysfunction, lumbar and cervical intervertebral disc displacement, lumbar muscles spasms, lumbar and cervical radiculopathy, cervical sprain/strain, myofascial pain

syndrome, and migraine. He prescribed Skelaxin and Elavil and ordered lumbar and cervical medial branch block (MBB) and TPI.

In August and September, Dr. performed bilateral lumbar TPIs for the postoperative diagnosis of fibromyalgia/myofascial pain.

On October 3, 2008, Dr. noted complaints of neck and low back pain. The injection given in September relieved the pain for about one week. The patient continued to complain of severe pain to the neck area radiating down both arms, with cramps and stiffness in the hands. She had an episode of paralysis to the neck area, when she was not able to turn neck side to side for about four days. The intensity was moderate-to-severe with pain level of 8/10. Dr. prescribed Mobic, Skelaxin, and Darvocet and recommended bilateral cervical and lumbar MBB.

MRI of the cervical spine showed multilevel neural foramina stenosis, degenerative disc disease (DDD), and C6-C7 left paracentral 3-mm disc herniation. X-rays of the cervical spine revealed a 2-mm anterior listhesis at C3-C4 and cervical muscle strain. X-rays of the lumbosacral spine showed L5-S1 disc space narrowing suggesting possible associated herniated disc and mild spondylosis.

Dr. noted that injections given on December 1, 2008, and March 7, 2009 relieved the neck pain for a while, but later pain returned in the neck area radiating down both arms and hands with associated weakness. She also complained of pain to lower back area radiating down both legs. Dr. recommended continuing medications, ordered left lumbar transforaminal L4, L5, and S1 epidural steroid injection (ESI).

On April 6, 2009, requests were made for following services: Bilateral cervical radiofrequency ablation at C4, C5, and C6; left lumbar transforaminal ESI at L4, L5, and S1; MRI of the lumbar spine; physical therapy (PT); and bilateral nerve conduction velocity (NCV) of the upper and lower extremities.

On April 10, 2009, the request for MRI lumbar spine was denied based on the following rationale: "*There are documented symptoms of chronic low back pain. Past diagnostic testing has included testing in the form of the lumbar MRI. The records available for review do not document the presence of any new changes on neurological examination. As a result, as would appear to be supported per criteria set forth by official disability guidelines (ODG), this request would not appear to be a medical necessity when it would not appear that there are any definitive new changes on neurological examination. Currently, medical necessity for this request is not established.*"

On April 23, 2009, there were appeals for the following services: Left lumbar transforaminal ESI at L4, L5, S1, bilateral cervical radiofrequency ablation at C4, C5, and C6, MRI lumbar spine, PT, and bilateral NCV of the upper and lower

extremity. There were letters of medical necessity for the following services: Transforaminal ESIs, cervical radiofrequency ablation, and MRI.

On April 30, 2009, the appeal for a repeat MRI lumbar spine was denied based on the following rational*: Based on physician advisor*.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. AFTER REVIEW OF THE AVAILABLE RECORDS, MRI OF THE LUMBAR SPINE REVEALED ONLY CHRONIC L4-5 DISC DESSICATION, ONLY, WITHOUT ANY SIGNIFICANT ABNORMALITIES SECONDARY TO INJURY, GIVEN THERE IS NO DOCUMENTATION OF NEUROLOGIC DETERIORATION ONLY ONGOING CHRONIC BACK PAIN MRI REQUEST IS NOT JUSTIFIED OR RECOMMENDED PER ODG.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES