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DATE OF REVIEW: May 1, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat lumbar MRI

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

Diplomate, American Board of Internal Medicine; American College of Occupational and Environmental Medicine

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

PATIENT CLINICAL HISTORY:

The patient is a male who reports an injury to his thoracic and lumbar spine on xx-xx-xx, after lifting 50-pound. He initially was reported to have sharp pain in his mid back and had thoracic spine x-rays which were within normal limits.

On September 4, 2007, the patient underwent a lower extremity nerve conduction study. He was now complaining of low back pain with pain referenced into the right lower leg. M.D. indicated that the patient had bilateral S1 radiculopathy secondary to delayed bilateral tibial H-waves. No EMG Study was performed. This does not meet AANEM criteria for diagnosis of radiculopathy.

On September 24, 2007, a repeat nerve conduction study was performed. Again, no EMG portion was performed. The sensory studies were performed of the sural nerves bilaterally, as well as the superficial peroneal nerves. It was noted that the patient's nerve conduction velocities were decreased bilaterally and the sural sensory latencies were delayed bilaterally along with a decrease in the conduction velocity of the right superficial peroneal nerve. From this, Dr. now concludes the patient has a sensory neuropathy in the lower extremities.

A thoracic spine MRI scan was within normal limits.

A lumbar spine MRI scan from September 26, 2007, revealed a 3 mm diffuse disc protrusion at L4-5, however, there was no evidence of encroachment on the neural foramina.

The clinical notes from October 4, 2007 indicated the patient was complaining of low back pain which was severe in nature and rated at 8 out of 10, radiating into the bilateral buttocks, bilateral hip, bilateral thighs, right greater than left; with muscle spasm, numbness, and tingling in the bilateral lower extremities.

The clinical notes from M.D., on November 7, 2007, indicated the patient had low back pain with reference into the right lower extremity. He complained of right leg weakness. On straight leg raising it was noted the right leg was positive at 30 degrees. It was noted that he had decreased sensation in the L4 through S1 disc dermatomes, as well as diminished ankle and knee reflexes in the right lower limb.

The clinical notes from April 22, 2007 indicated the patient was still complaining of low back pain rated at 9 out of 10. With flexion, he complained of bilateral buttock pain, bilateral hip pain, bilateral thigh pain, bilateral foot pain, right greater than left; with muscle spasm, burning, and tingling in the right leg and right foot.

A repeat lumbar MRI scan on May 13, 2008 was reported to reveal mild broad-based disc bulge and facet arthropathy with a mild degree of central canal and mild bilateral foraminal stenosis at both the L4-5 and L5-S1 levels. The description of the abnormalities is identical for both levels.

The clinical notes from May 20, 2008 indicated again the patient had mid and lower back pain rated at 8 out of 10. There was reference to the bilateral buttocks, bilateral hips, bilateral thighs, and bilateral knees; with weakness being noted in the bilateral knees. He also complained of bilateral leg severe numbness.

An EMG/nerve conduction study on August 26, 2008 was reported to reveal increased insertional activity with 1+ positive sharp waves and fibrillations in the right medial gastrocnemius and left medial gastrocnemius, with decreased recruitment in both muscles. It was also reported that there were 1+ polyphasic motor unit action potentials, with normal amplitude and normal duration. No paraspinal studies were performed. The proposed diagnosis was that the patient had bilateral mild acute radiculopathy; however, he does not explain **the** presence of the polyphasic motor units. Additionally, he performs no paraspinal muscle studies. The study does not meet AANEM criteria for the definition of radiculopathy with evidence of spontaneous activity in paraspinal musculature and in two distal muscles supplied by the same nerve root, but supplied by different peripheral nerves.

X-rays of the lumbar spine from January 27, 2009 revealed the patient had mild retrolisthesis of L4 on L5, however, no change in flexion or extension.

The clinical notes from January 27, 2009 indicated the patient was still complaining of low back pain rated at 6 out of 10, with burning, tingling, numbness, and shooting pains going into both legs.

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

In my opinion, I find no clinical evidence that there has been any significant change in the patient's clinical condition that would require the need for a third MRI scan. He has always continued to complain of bilateral low back pain with reference into the bilateral lower extremities; numbness, tingling, burning, and shooting pains into the bilateral lower extremities. Despite the multiple EMG studies and despite the MRI studies, the clinical condition has never changed. There is no reason to be clinically suspicious that something new has suddenly appeared at the L4-5 and L5-S1 levels without any evidence of a corresponding change in clinical condition. Therefore, I support the previous conclusion that medical necessity is not established for a third MRI scan.

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)**