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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the Lumbar Spine with Contrast

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

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates; Low Back- MRI

Review, Dr. 02/18/10

Review, Dr. 03/10/10

CT/myelogram Lumbar, 12/05/08

XR lumbar, 12/05/08

DDE, Dr. 02/27/09

Operative report, 07/27/09

Office notes, Dr. 08/18/09, 11/13/09, 01/15/10

Therapy Note, 01/04/10, 12/18/09, 12/28/09, 01/04/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant was involved in an accident. Initial treatment records were not provided for review. Reference was made to "multiple" lumbar surgeries with fusion at L4-5. Reference was also made to cervical and thoracic radiographs on 07/31/08 that were essentially normal; lumbar MRI on 10/14/08 that showed fusion at L4-5 with posterior osteophytic ridging and some foraminal narrowing without compression; electrodiagnostic studies completed on 10/17/08 that demonstrated lower extremity radiculitis; and lumbar radiographs from 11/11/08 with notation of attempted fusion L4-S1, partially united posterolateral fusion L5-S1 and bone growth stimulator leads. These reports were not provided for review. A lumbar CT/myelogram conducted on 12/05/08 noted mild degeneration with no canal or foraminal

stenosis L1-L4, moderate degeneration L4-5 with no stenosis and no significant extradural defect on myelogram. Lumbar radiographs also done on 12/05/08 noted L4-5 laminectomy with no other significant findings. A designated doctor evaluation conducted on 02/27/09 noted normal gait; ability to heel and toe walk; tenderness and spasm in the cervical, thoracic and lumbar spines; right lower lumbar palpation produced pain to the ankle; decreased sensation in the lateral right lower extremity; and intact strength and reflex findings.

The evaluating physician indicated fracture of the prior lumbar fusion and did not feel the claimant was at maximum medical improvement. The claimant underwent revision fusion on 07/27/09 with a diagnosis of pseudoarthrosis and residual stenosis at L4-5 with persistent axial and radicular pain. The operative report noted anterior posterior fusion with interbody cage, allograft and instrumentation. Postoperatively the claimant continued to have complaints of pain down the bilateral lower extremities. On 08/18/09 Dr. noted bilateral hip bursa tenderness and stable neurological examination. The claimant was wearing a lumbosacral orthosis. Recommendation was made to stay off nicotine, spinal stimulator and wean from the brace at eight weeks. On 11/13/09 Dr. noted the claimant had significant pain in the right heel and foot with difficulty walking. Lumbar radiographs noted apparent healing of the L4-5 fusion. Physical examination demonstrated lumbar tenderness, limited motion, gait abnormality due to heel pain, non tender sacroiliac joints, non tender bilateral greater trochanteric bursae; negative femoral stretch; and point tenderness in the plantar fascia. Physical therapy was started for the low back as well as the right heel and foot. Therapy notes on 01/04/10 indicated the claimant continued to require pain medications, ambulated with a limp, attempted to use a night splint but it caused her toes to go numb and the claimant did not make significant progress in therapy. On 01/15/10 Dr. stated the claimant had taken a clinical turn for the worse with complaints of cervical, thoracic and lumbar pain, pain down both legs and a lot of right heel pain. Physical examination demonstrated lumbar tenderness, limited motion, sacroiliac joint tenderness, subjectively intact sensation, normal strength, equal reflexes, negative straight leg raises and bilateral greater trochanteric tenderness with the right being greater than the left. Lumbar radiographs noted an apparent healed L4-5 pseudoarthrosis revision. Dr. noted he was unclear why the claimant had deteriorated and recommended CT evaluation to evaluate the fusion mass and MRI study with contrast to evaluate adjacent segment disease.

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

This is a woman who has had a long history of low back issues culminating in a most recent 07/27/09 revision L4-5 fusion. Postoperatively, she appeared to have done well and then developed progressive pain, stiffness, and limited motion. She has developed heel pain, and it does not appear that anything her physician or physical therapist have done have helped. Her physician would like to do a lumbar MRI with contrast to look at the adjacent segments, any sign of infection, epidural abscess, or late bleed that might be a space-occupying lesion causing her symptoms. ODG guidelines document the use of MRI testing as the choice test for patients with prior low back surgery, and they are indicated only if there has been a progression of neurologic deficit. In this case, since the claimant had been doing well and then was doing much worse and the fact that the claimant has radicular leg pains, then this reviewer believes that the MRI with contrast is medically necessary to rule out a space-occupying lesion such as an epidural hematoma or abscess or to rule out some type of unusual issue such as malposition of the hardware, and adjacent level disc herniation/ pathology. The reviewer finds that medical necessity exists for MRI of the Lumbar Spine with Contrast.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates; Low Back- MRI

MRI's are test of choice for patients with prior back surgery. Repeat MRI's are indicated only if there has been progression of neurologic deficit. Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care, are also candidates for lumbar MRI to evaluate potential for spinal interventions including injections or surgery.

Indications for imaging -- Magnetic resonance imaging

- 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.) (Andersson, 2000)
- 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

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)