

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** February 2, 2011

**IRO CASE #:**

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

MRI of the lumbar spine

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

Diplomat, American Board of Orthopaedic Surgery  
Fellowship trained in spine surgery

**REVIEW OUTCOME**

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

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male employed by who injured his back while lifting a computer server on xx/xx/xx.

On January 18, 2007, the patient was seen by M.D., for ongoing pain in the lower back radiating down the left leg into the foot. Dr. reported Initially the patient was evaluated in a local clinic and was prescribed pain medications and muscle relaxants. X-rays were unremarkable. Examination revealed tenderness in the left paraspinal muscles, decreased sensation along the left L5 nerve root distribution, reduced range of motion (ROM) of the lumbar spine and decreased strength in extensor hallucis longus (EHL) to 4/5. Dr. diagnosed lumbosacral pain and prescribed Medrol dose pack and Mobic.

Magnetic resonance imaging (MRI) of the lumbar spine revealed a broad-based disc protrusion at L5-S1 with annular tear, centered in the left lateral recess producing slight posterior thecal sac displacement and significant compression of the left L5 and S1 nerve roots. Moderate-to-marked left lateral recess and

proximal left neural foraminal stenosis. The disc abnormality produced mild effacement of the crossing right S1 nerve root.

The patient showed much improvement with the conservative treatment and was returned to full duty work by Dr. and recommended core strengthening exercises on his own.

On March 27, 2007, D.C., performed an impairment rating (IR) evaluation and assigned 15% whole person impairment (WPI) rating.

The patient did not return until December 1, 2010, to Dr. because of workers compensation issues and his employment. He now complained of pain in the lower back radiating to the left leg down to his foot. Examination revealed mild tenderness in the L5-S1 region and mild decreased sensation in the left L5 nerve distribution. Dr. diagnosed L5-S1 herniated disc and left L5 radiculopathy, prescribed Medrol Dose pack and ordered an open MRI of the lumbar spine to evaluate L5-S1 herniated disc and any possible nerve compression.

On December 10, 2010, M.D., denied request for MRI with the following rationale: *“As per the medical report dated December 1, 2010, patient presented with pain at the lumbosacral spine radiating to the left leg and foot. Upon physical examination, there was mild tenderness in the L5-S1 region but with symmetrical deep tendon reflexes in the lower extremities. Decreased sensation was noted; however, in the left L5 nerve distribution. The request was for a repeat MRI of the lumbar spine. The clinical information attached did not clearly state if there was a failure of conservative measures objectively documented by therapy progress reports and medication logs. In addition to this, the official results of the plain radiographic studies done on the patient were not provided for review. As such, this request for a repeat MRI of the lumbar spine without contrast was not established as of this time. Based on the clinical information submitted for this review and using the evidenced-based, peer reviewed guidelines referenced above, this request for a repeat MRI of the lumbar spine without contrast is not certified”*.

The patient wrote a letter to Dr. stating that the representative from had told him that surgery was not an option and he would have to live with the pain and this would be covered by the workers compensation claim as this was a permanent injury. Over the course, he received some physical therapy (PT) and medication to ease his pain and was later given a 5% disability. He had returned to work to full duty work as his company had made it clear in order to retain the job but within a month was terminated by the employer. He was still in severe pain and had realized how he had been misled. In November, he had started his new job and had to travel a lot, and lift tools. He complained of tremendous pain over the past year and a half. He then contacted Dr. who in turn requested a repeat MRI to see the current status of the disc. He requested Dr. to approve the same.

On January 7, 2011, M.D., denied an appeal for MRI lumbar spine with the following rationale: *“This appeal for a repeat lumbar MRI is not supported in the records by a formal prescription/recommendation or any supporting clinical documentation from the requesting physician. The only available justification for the requested repeat MRI is the patient’s personal account of his clinical progress. Records included the last lumbar MRI dated January 31, 2007. Prior*

*to a repeat MRI, records need to document significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). Owing to the lack of supporting clinical justification from the requesting provider, the medical necessity of the requested repeat lumbar MRI remains unsubstantiated in the records and therefore the previous non-certification was upheld”.*

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

**Rationale:** This patient was lifting a computer system on xx/xx/xx, and incurred a low back injury with pain into the left lower extremity.

He was evaluated on January 18, 2007, by Dr. (M.D.). He was noted to have back pain into the left lower extremity. The patient was on medication management. The patient had L5 distribution sensory change as well as decreased range of motion.

Subsequent MRI of the lumbar spine was completed, which showed broad-based disc protrusion with annular tear centered in the left lateral recess with significant compression of left L5 and left S1 nerve root as read by Dr. (M.D.) at Lumar Diagnostic Imaging.

The patient did have improvement in his symptoms such that he was placed at maximum medical improvement by Dr. on March 27, 2007, with a 5% impairment rating.

The next evaluation on this patient was December 1, 2010. The patient presented to Dr. noting increased symptoms into the left lower extremity. The impression was of an L5 radiculopathy with L5-S1 disc herniation. An MRI was ordered.

Prescription on December 1, 2010, signed by Dr. is for the lumbar MRI.

The December 12, 2010, typed version of the office note by Dr. indicates that there is weakness of the left extensor hallucis longus (EHL) as well as sensory change in the L5 distribution on his left lower extremity. The patient had tenderness on the L5-S1 levels.

There were pre-authorization review notices provided from by Dr., M.D., as well as Dr. M.D. There was also a letter from the claimant regarding the patient's dysfunction. He was reporting shooting pain and numbness into his left leg. The patient asked for the study to be approved.

Given the patient's clinical history and previous MRI findings and the recurrence of symptoms that would match an L5-S1 type distribution the reassessment of the lumbar spine anatomically with an appropriate high-quality MRI would be appropriate to assess what is or is not there. Thus the denials that had been forthcoming from Dr. and Dr. are not consistent with the clinical records in my assessment of the patient's history, the current symptoms, as well as the previous MRI.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
  
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**