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Notice of Independent Review Decision

DATE OF REVIEW: February 25, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRI lumbar spine without contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Fellow American Academy of Orthopaedic Surgeons

REVIEW OUTCOME

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

☒ Upheld (Agree)

Medical documentation **does not support** 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 xx-year-old male who fell leaning back in a chair that collapsed injuring his left shoulder and lower back.

2008 – 2009: M.D., evaluated the patient for complaints of pain in the left shoulder, lower back and the left wrist. History was positive for right shoulder surgery in 2003. Examination of the left shoulder revealed restricted range of motion (ROM), tenderness under the leading edge of the acromion, positive painful arc and mild crepitus. X-rays of the left shoulder were unremarkable while a magnetic resonance imaging (MRI) revealed impingement with subdeltoid bursitis, evidence of inferior surface fraying of the superior labrum and tendinosis

involving the subscapularis and supraspinatus tendon. The patient was treated with medications and therapy. Dr. diagnosed impingement of the left shoulder and lumbosacral strain. He treated the patient with a steroid injection into the left shoulder and medications.

In a designated doctor report, Dr. reviewed the second MRI of the shoulder and noted full thickness tear of the subscapularis tendon with 2 cm retraction, medial dislocation of the biceps tendon and partial thickness insertional tear foot plate of the subscapularis and evidence of subscapularis bursitis. Dr. opined that the injury to the lower back had resolved and had probably resulted in lumbar sprain and all the findings of the shoulder MRI were a direct result of the injury. He further stated the medial dislocation of the biceps tendon and full-thickness tear of the subscapularis tendon would require surgical repair along with acromioplasty.

2010: In May, Dr. noted the patient was four months status post repair of the scapularis tendon with a biceps tenodesis, acromioplasty and Mumford distal clavicle resection of the left shoulder. The patient had been through therapy and back to work. The patient was complaining of low back pain localized to the spinous processes of L3, L4 and L5. He treated the patient with a diclofenac and bupivacaine cream to the shoulder and back. Through September, the patient reported some postoperative pain in the left shoulder and also pain in the lower back radiating in the left groin and medial thigh associated with numbness, tingling and some weakness in the left lower extremity. Medications were continued and an MRI of the lumbar spine was ordered. In response to a letter, Dr. opined the patient had received therapy to his lower back in July 2008. According to him, he had mentioned lower back problems in April and May 2009, a after the injury. He further opined till date the treatment had only focused on the shoulder but the patient had ongoing complaints of low back pain. Hence, there was no problem with relating those complaints to the injury and an MRI was requested. If the study was unremarkable, then it could be written off as a strain and the patient could be placed at maximum medical improvement (MMI). The MRI scan of the lumbar spine was not authorized.

May 2010, patient listed by Dr with 14% whole person impairment (WPI) rating (21% to left shoulder, 2% to left wrist, 0% to lumbar spine, which converts to 14% WPI).

December 2010, Dr. noted some pain in the left shoulder and increasing complaints of low back pain and some left lower extremity radicular complaints. Hence, he felt this warranted an MRI scan years post injury.

2011: In January 2011, M.D., denied the request for MRI lumbar spine without contrast based on the following rationale: "*There are no current documented subjective complaints or a lumbar physical examination. There is documentation in prior medical records that low back symptoms had resolved as of May 13, 2008. Thus there is no need for a lumbar work up in 2011 given resolution of symptoms in 2008. Also a designated doctor placed this patient at MMI as of May 12, 2010 with a lumbosacral DRE category I which means ZERO impairment and which means no radiculopathy. ODG would not support lumbar MR imaging given the facts of this case*".

In January 2011, M.D., denied the appeal for MRI lumbar spine without contrast based on the following rationale: "*According to an October 2009 report, his low back injury resolved. Dr. saw the claimant in October 2010 for complaints of low back pain. On examination he had a normal gait, but limped on the left. He was able to heel/toe walk without difficulty and could squat ¼ of the way. There was tenderness to palpation of the paraspinal muscles on the left from T1 to the iliac crest and on the right from T10 to the iliac crest. There was also tenderness to palpation of the lumbar spine from T10 to the coccyx, tenderness to palpation of the sacrum and bilaterally at the iliolumbar ligaments, coccyx and left trochanter. He had 4 out of 8 positive Waddell's tests. Low back pain without objective signs of radiculopathy and symptom magnification were diagnosed. He was declared to be at maximum medical improvement as of May 2010 and assigned 0% impairment for the lumbar spine. The requested lumbar MRI is not medically necessary based on review of this medical record. This is a xx-year-old gentleman who has low back complaints. The medical record is somewhat questionable as to whether these complaints relate back to a xxxx injury since it would appear that in October 2009, Dr. documented that his low back complaints had resolved. From October 2010 onward, there are medical records documenting low back complaints, but there is no documentation in any of the medical records of an objective abnormal positive physical finding nor is there any documentation in the medical record of an x-ray or other evaluation of the lumbar spine. MRI testing is not the primary test for lumbar spine complaints and Official Disability Guidelines indicate its use in patients who have back pain with a red flag or patients who have obvious neurologic deficit or abnormal x-ray testing. In this case, there is no obvious red flag, no documentation in the record of neurologic deficit and no documentation in the record of an abnormal x-ray. Therefore, the requested lumbar MRI is not medically necessary based on these records*."

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

AS IS NOTED BY OTHER REVIEWERS, THE CLAIMANT WAS NOTED TO HAVE INITIALLY COMPLAINED OF LOWER BACK PAIN. BY DESIGNATED DOCTOR EVALUATION IN OCTOBER 2009, THE CLAIMANT'S LOWER BACK SYMPTOMS HAD RESOLVED. THE CLAIMANT'S FURTHER COMPLAINTS SEVEN MONTHS AFTER THE DESIGNATED DOCTOR EVALUATION DO NOT APPEAR RELATED THEREFORE AN MRI SCAN OF THE LUMBAR SPINE IS NOT REASONABLE OR NECESSARY. PER ODG, THERE WERE NO FINDINGS WHICH WOULD MEET THE NEED FOR MRI OF THE LUMBAR SPINE.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

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, other "red flags"

- 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