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Notice of Independent Review Decision

DATE OF REVIEW: 02/01/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Radiologic examination, spine, single view, specify level
Dates of Service From 12/21/2010 to 12/21/2010

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

Texas Licensed Chiropractor

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 11/22/05 - MRI Lumbar Spine
2. 10/11/10 - Clinical Note - Illegible Signature
3. 10/26/10 - Range of Motion & Manual Muscle Test
4. 12/22/10 - Utilization Review
5. 12/29/10 - MRI Lumbar Spine
6. 01/10/11 - Utilization Review
7. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx. The employee was handling scaffolding material and kept bending with his back. At the end of the day, he felt severe pain in the low back.

Prior medical records were reviewed. MRI of the lumbar spine performed 11/22/05 demonstrated normal findings at L1-L2 and L2-L3. At L3-L4, there was a mild annular bulge and evidence of a posterior annular tear at the left L3-L4 neural foramen. Mild facet degenerative changes were present. No focal disc protrusion, spinal stenosis, or neural foraminal narrowing was seen. At L4-L5, there was a prominent right central disc extrusion which narrowed the right and anterior aspect of the thecal sac. Some facet degenerative changes were present. There was no narrowing of the neural foramina.

At L5-S1, a prior laminectomy had been performed. A small amount of enhancing scar was noted immediately adjacent to the proximal left S1 nerve root. There was a broad bulge of the annulus present along with osteophyte formation. This slightly flattened the anterior aspect of the thecal sac. The appearance was more suggestive of a chronic disc bulge with osteophyte rather than a residual or recurrent disc protrusion. The bulge was relatively broad, and there was a mild degree of bilateral neural foraminal narrowing.

The employee was seen for evaluation on 10/11/10. The employee stated he was evaluated in the emergency room on the date of injury. The employee complained of low back pain with numbness and tingling in the left lower extremity. The employee rated the pain at 6 out of 10 on the visual analog scale. The employee denied any bowel or bladder dysfunction. Physical examination revealed slightly decreased strength up the extremities due to pain. Kemp's test was positive bilaterally. Faber's test and Yeoman's test were positive. There was tenderness to palpation with swelling bilaterally at L3 through L5. Vertebral muscle spasms were noted bilaterally at L3 through L5. Lumbar range of motion was restricted due to pain. The employee was assessed with herniated nucleus pulposus, myalgia, and muscle spasm. The employee was recommended for MRI of the lumbar spine and physical therapy.

The request for radiological examination, spine, single view, specify level was denied by utilization review on 12/22/10 due to no current examination results that reflected neurological compromise. All examination dates were two months old and the tests performed at that time did not indicate disc or neurological pathology.

An MRI of the lumbar spine performed 12/29/10 demonstrated normal findings at L1-L2 and L2-L3. At L3-L4, there was a diffuse symmetrical herniation of 2-3 mm slightly flattening of the ventral surface and were seen causing mild encroachment of the exiting foramina bilaterally. At L4-L5, there was a central and right paracentral disc extrusion of 5 mm compressing the sac and causing moderate compression of the right exiting nerve. There was a focal area of high intensity on the posterior aspect of the disc, suggesting annular rupture. At L5-S1, there was a diffuse symmetrical herniation of 4-5 mm causing moderate encroachment of the exiting foramen bilaterally. There was no sac compression noted.

The request for radiological examination, spine, single view, specify level was denied by utilization review on 01/10/11. The MRI showed some discal pathology without fracture, dislocation, or other bony pathology. With MRI completed, radiographs taken at the emergency room directly after the accident, and no red flags or physical trauma, repeat radiographs of the area would not be medically necessary.

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

The request for radiological examination was denied by D.C. on 12/22/10 and by D.C., on 01/10/11 due to a lack of any red flags. Based on the clinical documentation provided for review, it is unclear if the employee has any changes in physical examination. There is no reported trauma and no objective evidence of myelopathy.

Given the lack of any indications for radiographs, the medical necessity is not supported.

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

1. **Official Disability Guidelines**, Online Version, Low Back Chapter