



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: XX/21/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the Lumbar Spine
X-ray of the Lumbar Spine

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

Board Certified in Neurological Surgery

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

MRI of the Lumbar Spine - UPHELD
X-ray of the Lumbar Spine - OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Employer's First Report of Injury or Illness, xx/xx/xx
- Office Visit, xx/08/xx, xx/22/xx
- Lumbar Spine X-rays, xx/30/xx
- Evaluation, xx/09/xx
- EMG/NCS, xx/19/xx
- Physical Therapy Prescription, xx/19/xx, 06/09/xx
- Physical Therapy Evaluation, , 05/07/xx
- Physical Therapy, 06/18/xx, 06/21/xx, 06/23/xx, 06/24/xx, 06/25/xx, 06/28/xx, 06/29/xx, 06/30/xx, 07/xx/xx, 07/xx/xx, 07/06/xx, 07/07/xx, 07/09/xx, 07/13/xx, 07/15/xx, 07/16/xx, 07/21/xx, 07/22/xx, 07/23/xx
- Correspondence, M.D., 06/25/xx
- Rehabilitation Progress Note, 06/29/xx, 08/20/xx, 09/07/xx, 09/20/xx, 10/25/xx, 11/20/xx, 12/28/xx
- Second Opinion Evaluation, 08/10/xx
- Lumbar Spine MRI, 08/18/xx
- Evaluation, 09/xx/xx, 10/20/xx
- Case Report, M.D., 10/27/xx
- Correspondence, 11/xx/xx
- Employee's Request to Change Treating Doctors, 12/08/xx
- Evaluation, 12/28/xx, xx/25/xx, xx/xx/xx, xx/07/xx, xx/05/xx, 09/22/xx, 11/24/xx, xx/12/xx, xx/09/xx, xx/xx/xx, xx/30/xx, 05/25/xx, 06/05/xx, 07/06/xx, 07/26/xx, 08/13/xx, 09/28/xx, 11/xx/xx, 12/14/xx, xx/15/xx, 06/14/xx, 08/23/xx, xx/10/xx, xx/31/xx, xx/xx/xx, 05/xx/xx, 06/23/xx, xx/25/xx, 09/30/xx, 11/14/xx, 12/19/xx, 05/28/xx, 06/25/xx, 10/08/xx, 11/05/xx, 09/05/05, 12/20/10, xx/14/11
- Case Report, xx/17/xx, 10/31/xx
- Report of Medical Evaluation (RME), 06/07/xx
- Independent Medical Evaluation (IME), 10/13/xx
- Psychological Assessment, xx/05/xx
- Chronic Pain Program, xx/26/xx, xx/27/xx, xx/xx/xx, xx/xx/xx, xx/05/xx, xx/06/xx, xx/07/xx, xx/08/xx, xx/09/xx, xx/14/xx, xx/15/xx, xx/16/xx, xx/19/xx, xx/20/xx, xx/22/xx, xx/26/xx, xx/xx/xx, xx/09/xx, xx/16/xx, xx/27/xx, 05/07/xx, 05/08/xx, 05/14/xx, 05/22/xx
- Evaluation, xx/21/xx
- Evaluation, xx/06/xx
- Addendum, xx/30/xx
- Chest X-ray, 06/11/xx
- Lumbar Spine X-ray, 07/10/xx
- Operative Report, 07/10/xx
- Intraoperative Monitoring, 07/10/xx
- Statement of Medical Necessity, 08/06/xx, 09/30/xx
- Lumbar Spine X-rays, 08/13/xx

- Physical Therapy, 08/13/xx, 08/15/xx, 08/17/xx, 08/20/xx, 08/22/xx, 08/24/xx, 08/27/xx, 08/29/xx, 09/05/xx
- RME, xx/11/xx
- Epidural Pain Block, xx/21/xx
- Discharge Report, xx/22/xx
- Lumbar Spine CT Scan, xx/22/xx
- Lumbar Spine X-rays, xx/22/xx
- Medication Prescription, 09/30/xx
- Evaluation, 10/xx/xx, 11/xx/xx
- Decision and Order, 10/14/xx, 07/20/xx
- Right Knee MRI, 10/31/xx
- Review of Medical Records for Worker Comp/Legal Med Review, 11/11/xx
- Lumbar Spine CT, 12/12/xx
- Correspondence, xx/09/xx
- Functional Capacity Examination, 07/25/xx
- Medical Examination, 07/26/xx
- Lumbar Spine X-rays, 10/18/xx
- Correspondence, 12/xx/xx
- Pre-Authorization, 12/22/xx, xx/xx/xx, xx/18/xx
- Denial Letter, 12/28/xx, xx/20/xx
- Reconsideration Correspondence, 12/29/xx
- Addendum Letter, xx/06/xx
- Correspondence, xx/08/xx
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient apparently was on a bus when it made a sudden stop and she fell forward and landed on her knee. She was seen and treated. She complained of pain in her knee and back, which did not respond. The patient continued to be treated at a medical facility and had an EMG, which was totally normal, performed on xx/19/xx. A lumbar MRI scan showed some mild degenerative changes, but nothing of any significance.

The patient was then seen at a medical center, and thought to have degenerative disc disease. The physician subsequently performed a discography on her and reported that the discogram did show an L4-L5 disc tear. There was no report of what her response to it was, or the pressures involved. Subsequently, the patient had a psychological evaluation by a Dr., a social worker, and a chiropractor. She was felt to have a depressive disorder secondary to chronic pain, and a pain disorder associated with both psychological factors and a general medical condition of a chronic nature. She had physical disorders and conditions (injury related) with psychological stressors pointed out in his note. The patient had financial issues, as well as physical and hardship issues. Unfortunately, this psychological evaluation does not have an MMPI, which I think would have been very revealing in this patient.

The patient continued to see Dr. and had another evaluation by Dr. on xx/06/xx.

A neurosurgeon also evaluated the patient and felt that the request by Dr. for an L4-L5 laminectomy, decompression, discectomy, foraminotomy with bone grafting, and marrow with morcellation, and pedicle screw placement in titanium plates was indicated, and indeed it was performed on 07/10/xx.

The record subsequently revealed that the patient did fairly well for two months and then all of her problems came back, except that they were worse. She had numbness that was not present previously. She had more back pain; subsequently, therapy was tried, epidural steroids were tried, medications were tried, and none of it seemed to improve her. She was found to be at MMI by Dr. on xx/05/xx with a fifteen percent permanent partial impairment.

The patient continued to see Dr. for persistent back pain. She did not demonstrate any new neurological deficits; however, she had decreased range of motion of her lumbar spine. The x-rays showed the lumbar fusion with lumbar spondylosis and lumbar disc degenerative disease. It was felt that there was a micro-movement at the fusion site causing all of her pain. A CT of the lumbar spine, on xx/22/xx, was performed. The report states normal postoperative status described in the examination. No radiographic evidence of inflammatory process or soft tissue abnormality noted. No evidence of a fracture was seen. They identified the pedicle screws, et cetera. No mention was made of any lucency around the pedicle screws and no mention was made in the radiologist's report of a pseudoarthrosis. The plain x-rays were reported as a normal post-operative study.

The patient continued to be treated by Dr. and it was clear to him that she did have a pseudoarthrosis, the x-rays of which do not confirm that. I have only the reports; I do not have the films. He wanted to do an anterior lumbar interbody fusion on her, and it was not approved. She was continued under his care with various treatments tried, none of which afforded her relief. Finally, on 12/12/xx, a CT of the lumbar without IV contrast was performed in 3-D reconstructions and no mention is made in the dictation of pseudoarthrosis, but then again, nothing was mentioned about the fusion. I would think that were an effusion there and/or a pseudoarthrosis present, it would have been mentioned. There was no evidence of any listhesis with a neural foramina patent and stable alignment.

The patient continued to have low back pain and was continued to be followed by Dr. Dr. evaluated her on 07/26/xx, who felt that the surgery Dr. wished to perform was appropriate. At that time, the patient was five feet, two inches and 178 pounds, which was the lowest weight that I have seen in her records. Other lumbar spine films do not demonstrate fusion, pseudoarthrosis, or movement.

The note of xx/xx/xx by Dr. stated that there was no bone fusion on the sides. The CT scan with sagittal reconstruction confirmed the lack of bone fusion. However, the report that I read does not demonstrate that; again the films were not available.

Follow up then was scant until 2xx0, with no records for about five years. The patient returned with much the same complaints; poor sleeping, depression, hypertension, diabetes, anxiety, dyslipidemia, arthritis, and gastritis. She was on various medications. The same complaints were put forth and the neurologic examination revealed her to have straight leg raising at 45 degrees on the left and 40 degrees on the right. However, it did not mention if it was leg or back. She had evidence of decreased sensitivity at L4, L5, and S1 on the right, and C5 and C6 on the right, also. The lower extremity reflexes were brisk bilaterally and questionably in the upper arms. Tandem gait was impaired. Dr. Pisharodi recommended that she have an MRI, an x-ray to the lumbar spine with flexion/extension views, and an EMG NeuroScan of the lower limbs. She was started on Ultram.

Determinations by Dr., and subsequently by Dr., a neurosurgeon, did not certify that which was requested by Dr..

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

The MRI of the lumbar spine is not indicated. At this time, the claimant is many years post-operative. I think that an MRI of the post-operative back with hardware would be very difficult to discern. There was never any intraspinal compression, and I think that the most important issue at this time is the extra canal changes in the bone, usually best demonstrated by a CT scan with a high quality unit with additional flexion/extension films. Therefore, the x-rays with flexion/extension films of the lumbar spine, in my opinion, are medically reasonable and necessary.

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)**
- AMA GUIDES 5TH EDITION**