

SENT VIA EMAIL OR FAX ON

Jun/13/2011

## True Decisions Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/13/2011

**IRO CASE #:**

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

Repeat MRI Lumbar Spine with and without Gadolinium

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

MD board certified anesthesiology/pain management

**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**

#### PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate the injured employee was lifting a heavy wooden object weighing about 90 pounds when he experienced sharp pain in the left lower back. The injured employee has a history of previous lumbar spine surgery performed 11/20/09 indicated to be an eclipse fusion at L4-5. Since surgery the injured employee has continued with pain and radicular symptoms down the left leg. MRI of the lumbar spine performed on 07/10/10 reported disc desiccation with prominent Schmorl's node at L4-5; no significant disc bulging or herniation; normal appearance of individual nerve roots and lumbar spine nerves; normal facet joints and paravertebral soft tissues. Injured employee was seen for new patient consultation by Dr. on 04/20/11. Examination at that time reported the injured employee to be 5'9" tall and 160 pounds. There was paravertebral tenderness and mild spasm of the lumbar spine. Straight leg raise was positive on the left at 60 degrees and mildly positive on the right at 75 degrees. Motor function appeared to be intact in all major muscles of the lower extremity. Sensory examination revealed decreased L5 on the left. Reflexes appeared to be brisk and equal bilaterally. X-rays of the lumbar spine were noted to reveal disc space narrowing at L4-5 with interbody device on the right side. Flexion extension views indicated some instability at L4-5 with increased translation of greater than 4mm and increased angulation change of greater than 11 degrees. Assessment was status post previous surgery at L4-5 with L5 radicular symptoms and mechanical back pain secondary to a degenerative disc at L4-5.

A request for repeat MRI of the lumbar spine with and without gadolinium was reviewed on 04/29/11 and determined to be non-certified as medically necessary. It was noted that patient evaluation on 04/20/11 revealed continued complaints of radicular symptoms down the leg with objective findings of lumbar paravertebral tenderness and mild spasm, positive straight leg raise test on left at 60 degrees with mild positive straight leg raise right at 75 degrees, decreased sensation on the left L5. The date of the last MRI and corresponding imaging results were not documented for comparison. The injured employee underwent eclipse fusion at L4-5 on 11/20/09. There was no objective evidence that the injured employee had maximized benefits from a recent course of conservative management inclusive of optimized pharmacotherapy, activity modifications and physical therapy. No clearly stated rationale for the requested repeat lumbar MRI was provided. There was no clearly expressed need for proposed updated imaging study in evaluating potential of spinal interventions including injections or surgery.

An appeal request for repeat MRI of the lumbar spine with and without gadolinium was reviewed on 05/18/11 and the request determined to be non-certified. It was noted that the injured employee was status post eclipse fusion at L4-5 on 11/20/09. He complains of lower back pain with radicular symptoms to the left lower extremity. Examination revealed paravertebral tenderness and mild spasm, positive straight leg

raise, intact motor function, decreased sensation in the L5 distribution, and brisk and equal reflexes. The clear rationale for the requested imaging study was not seen in the records submitted for review. Official report of recent plain radiographs was not included. There also was no objective documentation provided with regard to the failure of the injured employee to respond to conservative measures such as oral pharmacotherapy and physical therapy. The case was discussed with PA, and it was noted the request for MRI and EMG came from Dr. an orthopedist since the injured employee continued to have symptoms. was to fax the orthopedist's notes. Physical therapy and other conservative treatment reportedly have failed following back surgery pending further information, the request for repeat MRI with and without gadolinium was not certified as medically necessary.

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

Based on the clinical data provided, the request for repeat MRI of the lumbar spine with and without gadolinium is/is not seen as medically necessary. The injured employee is noted to have sustained a lifting injury to the low back in xx/xx. He is status post eclipse fusion procedure performed 11/20/09. He continues with complaints of low back pain with radicular symptoms down the left leg. Examination revealed motor and reflexes intact. There was decreased sensation in the left L5 dermatome. Straight leg raise was positive on the left at 60 degrees and mildly positive on the right at 75 degrees. Reference was made to plain radiographs including flexion / extension views. As noted on previous utilization review determinations, no radiology reports of these x-rays were submitted. There is no comprehensive history of conservative treatment completed following surgical intervention in 2009 until the injured employee was seen in follow-up by Dr. on 04/26/11 to include medications, physical therapy, and injections. There are no serial examination findings indicating a progressive neurologic deficit or significant change in symptomatology. There is no clear indication that the injured employee is a candidate for invasive treatment such as injections or further surgery. As such, medical necessity is not established.

#### **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)