

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 03/17/2011

IRO CASE #:

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

This case was reviewed by a Pain Management doctor (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the lumbar spine between 1/4/2011 and 3/5/2011

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 10-01-09 Lumbar MRI
- o 10-01-10 Left wrist, hand and lumbar spine x-rays
- o 10-01-09 Left hand and left wrist MRIs
- o 01-04-10 Request to send patient to clinic from Dr.
- o 07-16-10 PT progress notes from Dr.
- o 07-21-10 Fax Cover from Dr. request for PT x 12
- o 12-06-10 Provider notes from Dr. with request for MRI
- o 12-29-10 Physician note from Dr.
- o 12-14-10 Utilization Review report
- o 12-14-10 Adverse Determination Letter
- o 01-07-11 Peer Review for lumbar MRI on appeal
- o 01-10-11 Adverse Determination letter for reconsideration.
- o 02-14-11 Designated Doctor Examination
- o 02-22-11 Request for IRO from the Claimant
- o 02-23-11 Designated Doctor Examination report cover letter from Dr.
- o 02-24-11 Confirmation of Receipt of Request for IRO
- o 02-28-11 Notice of Case Assignment
- o 03-02-11 Fax cover - medical records sent with ROM studies

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female employee who sustained an industrial injury to the low back, right knee and left wrist and hand when she tripped, landing on her left wrist and right knee. She is status post a right knee arthroscopy with partial lateral meniscectomy on June 2, 2010 and excision of tendon scar tissue at the left wrist in September 2010 and is followed by a pain management specialist for continuing low back complaints. Co-morbid conditions include Diabetes mellitus and obesity (5' x"/XXX pounds).

The patient initially attended PT. A PT progress note dated July 16, 2010 indicates dull and achy pain of 7-8/10 at the right knee. ROM is 0-100 degrees and strength 3/5 with flexion and 3+/5 with extension. She is improving with therapy. Additional therapy with progression to Phase II was recommended x 12.

Radiographs taken October 1, 2009 showed unremarkable studies of the left wrist and hand. Lumbar radiographs showed slight narrowing of the L5-S1 disc space.

Left wrist MRI performed on October 1, 2009 showed a 1.4 x 1.0 x 0.4 cm fluid signal intensity structure along the dorsal aspect of the wrist that appears to be located adjacent to the extensor tendons and particularly the extensor pollicis longus tendon. No extension to the articulations of the osseous structures is identified as would be seen with a ganglion cyst. However, this may instead represent a peritendinous cyst.

Left hand MRI performed on October 1, 2009 showed no abnormality of the left hand.

Lumbar MRI performed on October 1, 2009 showed disc pathology seen at the L3-4 and especially L4-5 and L5-S1 levels: At L3-4, posterior 1-2 mm disc protrusion presses on the thecal sac and narrows the medial aspect of the neural foramen on each side. At L4-5, posterior 3 mm disc protrusion/herniation presses on the thecal sac with no neural foraminal narrowing. At L5-S1, there is posterior 7 mm disc protrusion/herniation impinging on the thecal sac and also on the right more than left S1 nerve roots as they emerge from the thecal sac on each side. No neural foraminal narrowing is present. No facet disease or spinal stenosis is seen at any lumbar level.

The patient underwent a right knee arthroscopy on June 2, 2010.

The patient attended a Designated Doctor Evaluation on August 10, 2010. The report is not available but the DD later cites this examination noting that he felt there was symptom magnification and he found no significant back findings other than absent bilateral Achilles reflex which he felt could be due to Diabetes mellitus, particularly in light that she was not taking her medications since she had an expired Medicaid card.

On November 1, 2010 the patient was seen by a neurologist for neurological evaluation and nerve studies (as reported by the DD on 2-14-11). He did not feel there was any obvious weakness in the right tibialis anterior on testing; she seemed to give it less effort on that side. His impression was there was no consistent evidence of radiculopathy. He felt she had low back pain but there was an element of symptom magnification. It was his belief that without any objective evidence of neurological damage, she should be treated conservatively.

December 6, 2010 reevaluation with her pain management provider noted a fall resulting in back pain traveling to the right leg into the foot. She has not received specific treatment as compensability issues were involved. She can only flex to 25 degrees. Right straight leg is positive. Clear weakness was seen in the right gastrocnemius and soleus group. There was 1 cm atrophy of the right calf. Right ankle reflex was absent. MRI of October 2009 was reviewed and showed a large disc herniation at L5-S1, which did abut and displace the right S1 nerve root. She needs an updated MRI.

The patient was provided a second surgical opinion on December 17, 2010 (as cited by the DD): He noted numbness in the right leg in a stocking-type distribution and increased numbness in the right great toe. He felt that requests for repeat MRI, a neurological examination and EMG/NCV were appropriate.

Request for one MRI of the lumbar spine between 12/9/2010 and 2/7/2010 was considered in review on December 14, 2010 with recommendation for non-certification. 14 pages of documentation were reviewed. The documentation submitted for review elaborates the patient able to demonstrate 25 degrees of lumbar flexion. Evidence based guidelines recommend a repeat MRI provided the patient has demonstrated significant changes in symptomatology or pathology. The documentation submitted for review does not elaborate into the patient's significant changes in pathology or symptomatology (e.g tumor, infection, fracture, neurocompression, and recurrent disc herniation).

Provider note dated December 29, 2010 provides additional rationale for updated lumbar MRI. The denial noted significant changes in symptomatology or pathology are needed to warrant repeat MRI. The patient now demonstrated, and did demonstrate on December 6, 2010, tenderness in the right sciatic notch. There was positive straight leg raise on the right at 30 degrees. There was clear weakness in the right gastrocnemius and soleus group with atrophy of the right leg. All of this was new and indicated progressive neurologic deficit.

Repeat request for lumbar MRI was reconsidered in review on January 7, 2011 with recommendation for non-certification. Per the reviewer, the patient tripped and was treated for a sprain of the left wrist and right knee. She underwent right knee surgery in June 2010. Lumbar MRI of October 2009 showed dehydration of the L4-5 and L5-S1 with remaining lumbar disc adequately hydrated. Type 1 changes are seen in the bone marrow adjacent to the L5-S1 disc space. There is a posterior 7 mm disc protrusion/herniation at L5-S1 impinging on the thecal sac and also on the right more than left S1 nerve roots as they merge from the thecal sac on each side. On December 6, 2010 the patient was noted to have radicular symptoms traveling to the right foot. Examination showed tenderness at the right sciatic notch. Forward flexion was to only 25 degrees. She had pain with straight leg

raising on the right at 30 degrees. There was weakness in the right gastrocnemius and soleus group and atrophy and loss of ankle reflex. The current report states all these findings are new. A peer discussion was attempted but not realized. Rationale for denial notes, the findings are stated to be new and indicated progressive neurological deficit. However, failure to respond to exhaustion of recommended conservative treatments such as oral pharmacotherapy or rehabilitation was not objectively documented through VAS pain scales and serial PT progress reports.

The patient returned to the Designated Doctor on February 14, 2011. The patient complains of intermittent low back pain with occasional paresthesias transversely at the L4-5 level. She also reported occasional paresthesias in the right lower extremity in a stocking type fashion, which goes from the hip to the foot. She stated the paresthesias are most prominent in the right great toe. She has no left wrist complaints and her right knee is doing well. She has been followed by her pain management provider since August 8, 2009. At initial examination her straight leg raising test was negative and her sensory exam was normal in both extremities. She had x-rays of the low back which were interpreted as normal. She was diagnosed with an abrasion of the right knee, a sprain of the left wrist and elbow and of the lumbar spine. She was given Darvocet and Mobic and allowed to continue light duty. There was no light duty work and she never returned to work. On September 25, 2009 she was started with chiropractic treatment. Her pain continues and MRIs were done on October 1, 2009. He was sent to a second pain management physician who felt she had a disc herniation, radiculopathy and facet disease at L5-S1 as well as S1 neuritis bilaterally as well as traumatic arthritis of the left wrist and right lower extremity. In November 2009 a plastic surgeon recommended excision of a left wrist ganglion cyst. Medications were increased that month. According to a DD evaluation of November 23, 2009 she was not at MMI, she had a left wrist ganglion cyst, a lumbosacral strain with HNP at L5-S1 and could only do sedentary work per an FCE. Knee MRI of December 2009 noted a low-grade sprain of the ACL. Synvisc injection was provided in January 2010. The left wrist cyst was excised on January 13, 2010. In January 2010 there was an EMG/CVD done by a chiropractor who described himself as an electrodiagnostic practitioner. He noted the motor and sensory nerve studies were normal but the h-reflexes involving the tibial nerves were prolonged bilaterally and he reported the EMG as positive for an active denervation process involving the bilateral S1 nerve roots. The patient attended more chiropractic/physiotherapy in February 2010. Arthroscopic surgery of the right knee was done on May 19, 2010. The prior DD report of August 10, 2010 is cited (see above). She underwent excision of a left wrist cyst in September 2010. The patient related that she was recently sent to a spine surgeon who told her she would most likely require a back surgery. She stated she wanted a second opinion as she felt the back was getting somewhat better and the symptoms were subsiding. On February 2, 2011 peer review was conducted and it was determined there was no need for manual muscle testing, additional meds, PT or other medical treatments. She stated that she is still going to pain management courses but feels that these sessions are no longer beneficial or necessary.

According to the Designated Doctor, the patient is 5' x" and XXX pounds. She had no difficulty going from the sitting to the standing position or when getting on and off the exam table. She walked with a normal gait and did not appear to be in any pain. The low back exam revealed increased lordosis with minimal tenderness to palpation across the lower lumbar spine. There was no paraspinous spasm. She was able to forward flex and touch her fingers to her ankle and could extend 10 degrees. She had 30 degrees of lateral bending and the motions were smooth and symmetrical and accompanied by minimal pain. Knee jerks were symmetric 1+. Ankle jerks were symmetrically lacking. Sensory exam revealed normal sensation in all areas tested to light touch. No motor weakness was found. Sitting straight leg raise was negative to 90 degrees bilaterally but positive supine on the left at 70 degrees and on the right at 60 degrees. Diagnosis is status post excision traumatic ganglion cyst left wrist, lateral meniscal tear, right knee, status post arthroscopic surgery with partial lateral meniscectomy right knee, lumbosacral strain, MRI evidence of a 7 mm disc herniation, L5-S1 on the right which contacted the right S1 nerve root and marked reduction in the lumbar pain.

Request was made for an IRO.

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

ODG: MRI is warranted for patients with uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit or when myelopathy is present or other red-flag conditions such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care.

The patient is XX months post injury. She had a tendon scar excised from the left wrist about 14 months prior and does not currently have wrist complaints. She had a right knee arthroscopy 9 months prior with a good outcome and she does not have knee complaints at this time. According to an FCE and DD opinions she can only do sedentary work. She has never returned to work, as no light duty is available. She has diabetes mellitus but has not been using medication (in August 2010) as her Medicaid card expired and she had not yet obtained a new one. On February 14, 2011 she stated to the DD, she is still going to pain management courses but feels these sessions are no longer beneficial or necessary. The recent DD examination shows normal gait, increased lordosis with minimal tenderness to palpation across the lower lumbar spine, no paraspinous spasm, forward flex with fingers to the ankle, extension of 10 degrees. She had 30 degrees of lateral bending and the motions were smooth and symmetrical and accompanied by minimal pain. Knee jerks were symmetric 1+. Ankle jerks were symmetrically lacking. Sensory

exam revealed normal sensation in all areas tested to light touch. No motor weakness was found. Sitting straight leg raise was negative to 90 degrees bilaterally but positive supine on the left at 70 degrees and on the right at 60 degrees. Prior examinations have indicated pain behaviors. The most recent provider notes state she has new signs of radiculitis. If new clinical signs are found, a new course of conservative treatment would be needed, which has not been documented. If the DD examination is accurate, there are no clinical signs to raise suspicion for a lumbar radiculopathy and special imaging would not be needed.

Therefore, my recommendation is to agree with the previous non-certification for MRI of the lumbar spine between 1/4/2011 and 3/5/2011

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines 02-17-2011 Lumbar Chapter - Magnetic resonance Imaging:

Recommended for indications below. MRI's are test of choice for patients with prior back surgery. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation).

Diagnostic imaging of the spine is associated with a high rate of abnormal findings in asymptomatic individuals. Herniated disk is found on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging disks, in 20% to 81%; and degenerative disks, in 46% to 93%.

The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized

diagnostic imaging such as magnetic resonance imaging (MRI) without a clear rationale for doing so. A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients.

Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. There is support for MRI, depending on symptoms and signs, to rule out serious pathology such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care, are also candidates for lumbar MRI to evaluate potential for spinal interventions including injections or surgery.

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