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Notice of Independent Review Decision

DATE OF REVIEW: October 10, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the Lumbar Spine. CPT Code: 72148

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

FAMILY PRACTICE
PRACTICE OF OCCUPATIONAL MEDICINE

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

Medical records from the Carrier/URA include:

PATIENT CLINICAL HISTORY:

The patient presented with a history of neck, low back, and shoulder pain on the initial evaluation of xx/xx/xxxx. She had had pain for one week prior to her presentation. She treated initially with over-the-counter inflammatory agents. She noted numbness in both hands since the incident. Neurological assessment was positive for paresthesias and weakness. The assessment was neck pain, lumbar strain, sprain/strain of the shoulder, and thoracic strain. She was given Prednisone taper and Flexeril for spasm. X-rays of the neck, thoracic and lumbosacral spine, and shoulder were ordered. She was given an intramuscular injection of Decadron and an injection of Toradol 15 mg as well. The patient was

returned to work in a restricted capacity.

In follow up July 6, 2011, no persistent hand paresthesias are noted, but persistent back and limb pain were noted. The diagnosis remained unchanged: thoracic, lumbar, and shoulder strain and neck pain. The patient was continued on light duty. Physical therapy was recommended.

In follow up July 11, 2011, facial numbness is reported and pain and numbness of both of the patient's hands for approximately a week. The diagnoses remained unchanged. She was to continue with physical therapy. The evaluating provider, M.D., opined these symptoms were not related to her injury. He recommended that she follow up with her primary care physician. Neurological assessment was completely normal.

In follow up August 1, 2011, there was pain in both shoulders, the right worse than the left, radiating down both arms, and low back pain. There were no focal neurological deficits on physical examination by Dr. The diagnosis remained unchanged: lumbar sprain/strain and strains of the shoulder and neck pain. The patient was given Lodine and continued on light duty. It was recommended she follow up with Dr. for evaluation of her symptoms. Physical therapy assessment revealed deficits of cervical range of motion as well as some mild deficits of mild shoulder strength, 4+/5, with regard to the flexors, internal rotators, and external rotators.

Xxxx describes diffuse nonspecific complaints as follows: hip pain, paresthesias in the legs, no abdominal pain, no signs of any neurological dysfunction, and no problems with continence. Physical examination revealed normal cervical alignment with essentially normal range of motion of the cervical spine. The assessment was degenerative disc disease, low back pain, and lumbar sprain. The recommendation was for an MRI of the lumbar spine and x-rays of the lumbar spine two views. Neurological assessment indicated resolution of the previous tingling and paresthesias; there was none noted per M.D., consulting on August 19, 2011, due to persistent pain complaints. There was radiation to both arms, right greater than left, and numbness in both hands. However, this did not translate to actual sensory changes on provocative testing. The diagnoses remained spine sprain and shoulder sprain. The patient was given an injection of Toradol.

In follow up August 26, 2011, motor examination by Dr. notes none of the previous weakness in the patient's shoulder. Strength is described as 5/5 in all muscle groups of the upper and lower extremities. Deep tendon reflexes were symmetrical and brisk. She was continued on Cyclobenzaprine. It was Dr. opinion that, "It is unlikely that some of these are related to the injury she states occurred on 6/22/11 when the sliding doors closed on her shoulders while at work."

In a peer review by M.D., she did not feel there was sufficient documentation in the medical record to corroborate medical necessity for an MRI given, "The claimant has symptoms throughout her body which do not appear to follow a specific dermatome. No objective and focal neurological deficits were present."

In follow up September 10, 2011, Dr. reiterated his previous contention that the level of the symptoms the patient was experiencing were unlikely caused by her reported mechanism of injury. "Given the fact that there were no contusions, abrasions, visible swelling, or deformities at the occurrence of the injury, it is likely that any soft tissue damage would have healed as this point." He opined the patient was at maximum medical improvement and recommended a functional capacity evaluation.

In follow up September 21, 2011, the diagnoses remained unchanged: lumbar sprain, neck pain, and sprain/strains of the shoulder. It is noted the patient had had extensive radiological testing to include the ribs, ankle, foot, hips, spine, sacrum, coccyx, elbow, hand, and wrist. There is no notation of any underlying pathology in the medical record related to her radiological studies. Her medications included Etodolac and Vicodin at that time, per Dr.

In physical therapy evaluation of September 26, 2011, the patient was reported to have persistent deficits of cervical range of motion, mild in degree, and similar deficits of lumbar range of motion. There were some strength deficits described

bilaterally in the shoulder, 3/5 on the left and 4/5 on the right, which appeared to be global across all muscle groups. It has previously been noted that she had normal strength throughout. As a matter of fact, this appears to be consistent with approximately 3/5 strength throughout the entire left side of her body and 4/5 on the right side of her body. Reflexes, however, were symmetrical and brisk. Sensation was reported to be grossly intact. Goals for short term and long term functional recovery were set. The anticipation would be for long term goals to be achieved within two weeks.

Per the follow up evaluation of September 29, 2011, it was Dr. contention that the patient was at maximum medical improvement and an impairment rating had been scheduled. It was noted the patient was very tearful with a flat affect at that time. It was recommended that she follow up with her primary care physician. Due to the severity of the patient's abdominal complaints, she was referred to the emergency department for further evaluation of her abdominal pain. "I am concerned that there may be an underlying problem non-related to her injuries that could be causing her abdominal pain. The patient has been informed of concerns and I have contacted the emergency room to apprise them of my concerns."

CT of the pelvis without contrast revealed no fracture or dislocation involving the sacrum or coccyx. Bilateral hips appeared intact without any fracture and no posterior subcutaneous soft tissue density or hematoma was noted. This was performed September 30, 2011, and read by M.D. There were no ascites but there was some evidence of constipation.

I have the reports of previous imaging studies. I have lumbosacral spine two views. The impression was lumbar spondylosis and rightward directed scoliosis without lumbar vertebral body compression, deformity, or spondylolisthesis, as read by M.D., on August 11, 2011.

I have no further documentation.

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

I cannot state that the MRI of the lumbar spine is reasonable or necessary. There is no indication of any type of ongoing process. Plain films of the lumbar spine revealed degenerative changes only. The working diagnosis has remained spine strain of the cervical, thoracic, and lumbar spine and shoulder strain. The mechanism of injury is described as a freezer door closed on the patient's shoulders, and this would have very little to do with the lumbar spine. I cannot state there is any causal relationship between the mechanism described and the patient's back pain. There has been nothing in her records to corroborate any underlying neurological deficit which could be related to an underlying spine process. The nature of the patient's complaints appear to be diffuse and nonspecific, and her treating physician stated that there was no evidence of

trauma to indicate any significant soft tissue or bony tissue disruption as a result of the injury. As such, I cannot say that medical necessity is corroborated.

I reviewed the indications for MRI imaging for low back injuries per the ODG Guidelines. They are as follows: lumbar spine trauma with fracture or neurological deficit. There is no evidence of a lumbar spine trauma; the treating physician notes no evidence of any type of soft tissue injury and the injury was described as a door closing on her shoulders rather than the spine. It is also indicated for low back pain with a suspicion of cancer or in the case of radiculopathy. There is no notation of any consistent pattern of radiculopathy that I can appreciate. In addition, prior lumbar surgery or cauda equina syndrome, the patient does not meet any of these criteria. Finally, myelopathy, there is no documentation in the medical records of myelopathy. As such, I cannot corroborate the necessary of MRI in this case.

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)