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Notice of Independent Review Decision

August 8, 2012

DATE: August 8, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI Thoracic Spine W/O Contrast 72146

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

This physician is Board Certified by the American Board of Occupational Medicine with over 34 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

MRI Thoracic Spine W/O Contrast
Consultation
MRI Cervical Spine W/O Contrast
MRI Lumbar Spine W/O Contrast
Physical Therapy Evaluation
Progress notes
Followup by, MD
Physician Record
Physician Record

Physician Record
AP & Lateral View of Thoracic Spine, Three-View Lumbar Spine
Physician Record
UR
UR

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his mid and upper back when he was struck in his head at work, and his neck was hyperextended

MRI Thoracic Spine W/O Contrast

IMPRESSION: Mild compression of vertebral body of T7 is old and not new. No intraspinal or paraspinal hematoma is identified. Posterior osteophyte formation of T7 with mild disc desiccation and decreased disc space at the level of T6-T7 and T7-T8 and minimal disc bulging. No impingement upon the nerve root is identified.

The claimant was evaluated by MD who noted that he complained of a two-week history of neck pain and mid to upper back pain after a work injury. He stated that immediately after the injury, he had numbness and tingling going down his right upper extremity, which had since resolved. He had been managing his symptoms with Lortab. He reported persistent neck pain radiating down to the interscapular region of his upper back. He denied any radicular symptoms at that time. On physical exam, he had a normal gait. He had tenderness to palpation along the lower thoracic spine. He had significant neck pain with cervical spine hyperextension and also significant back pain with back hyperextension, specifically at the lower thoracic region. He had 5/5 strength in the upper and lower extremities bilaterally. Sensation was intact. Long tract signs were negative. Reflexes were intact and symmetric bilaterally. Review of his MRI scan of the thoracic spine showed a wedge defect of the T7 vertebral body without significant edema. PLAN: I would like to get an MRI scan just to make absolutely certain that the abnormality that is seen in the plain films is not significant. In addition, we will have an MRI scan done of his lumbar spine. I do believe that he will benefit from a course of therapeutic exercises for both the neck and the low back. We will place him on Meloxicam, Tizanidine, and then plan to check him back in approximately 3-4 weeks. We will obtain the results of the MRI scan and then give them notice whether or not to proceed with the physical therapy. Of note, he is currently not working. I stated that most patients only get better over 8-12 weeks, but also depending on how quickly they respond. Fortunately, he is young and hopefully will respond at a much fast pace.

MRI Cervical Spine W/O Contrast. IMPRESSION: Minimal uncinata spurs noted bilaterally at C4-C5 and C5-C6 with minimal bilateral neural foraminal narrowing.

MRI Lumbar Spine W/O Contrast

. IMPRESSION: Possible transitional level. For the purposes of this study, the most inferior disc space is regarded as L5-S1. No signs of central canal or neural foraminal stenosis.

The claimant was evaluated by physical therapy. He complained of upper back/between shoulder blades soreness and low back pain rated 5/10. Range of motion: Shoulder flexion 180 bilaterally, Shoulder abduction 180 bilaterally, cervical spine WNL. ASSESSMENT: Cervical ROM is WNL with a painful stretch in the upper trapezius. Left arm weaker than the right side. Muscle tightness was noted with STM to the upper trapezius on the left side. TREATMENT PLAN: Patient Education/Written HEP, gait training, balance training, ROM/stretching activities, spinal stabilization, body mechanics training, postural education, electrical stimulation, hot/cold packs, therapeutic exercise, neuromuscular re-education, manual therapy, aquatic therapy, therapeutic activities, and group therapy.

Progress notes. The claimant attended physical therapy sessions where he completed all exercises. He reported soreness in mid scapular region after last treatment session. His cervical spine ROM was WNLs with the exception of right cervical side bending, which was limited due to muscular tightness. Bilateral UE MMT was 5/5 with the exception of right and left shoulder ER 4/5. Strengthening was completed with no complaints. He was discharged.

The claimant was re-evaluated by MD, at which time he stated that therapy was not helping him. He noted soreness in his neck as well as in his mid and lower back. On examination, there was only slight paraspinal tenderness in the mid cervical spine and minimal of the mid lumbar. Reflexes at the upper and lower extremities were symmetrically diminished. Sitting root test was negative. Spurling's maneuver was negative. Dr. reviewed his MRI scan of the lumbar spine and noted that he had normal discs. He noted that the cervical spine again showed normal discs without any significant abnormality. PLAN: While feels good and would like to go back to work, I would like him to undergo an FCE. If indeed this shows that he has the functional capabilities to return to work, we will give him a full release. If not, then he will go through work hardening program. We will make arrangements for the above. Of note is that his physical therapist had given him a release for home exercise program, but again because his work is heavy, I would like him to undergo an FCE.

The claimant was evaluated by MD for followup of injury. It was documented that his response to therapy was improved with good compliance with therapy. He complained of some pain in the neck but was much better. On physical exam, he had no tenderness in the extremities with normal extremity ROM and normal gait. His neck was nontender. He had mild soreness in the mid back with painless ROM. Motor exam, sensation, and reflexes were all normal. TREATMENT PLAN: Return to work. MMI released to full duty, no restrictions. WORK INJURY DIAGNOSIS: Cervical and thoracic strain.

The claimant was re-evaluated by MD for complaints of increased mid back pain after standing for 30-40 minutes as well as neck pain when leaning head back. On physical exam, he had normal inspection of the neck, which was nontender,

with painless ROM. He had muscle spasm in the left side of the mid back with decreased ROM. Motor, sensation, and reflexes were normal. TREATMENT PLAN: Physical therapy 3 times per week x 2 weeks. He was given a prescription for Flexeril.

The claimant was re-evaluated by MD for complaint of “pop” in his back. He had point tenderness in the thoracic/lumbar spine. It was noted that he had burning, sharp, radiating, severe pain rated 8/10 that was relieved by nothing. On physical exam, he had muscle spasm in the mid back with vertebral tenderness. He had normal motor strength, sensation, and reflexes. He was given a prescription for Flexeril and Tramadol. X-rays of the thoracic and lumbar spine were ordered. He was taken off work for one week.

AP & Lateral View of Thoracic Spine, Three-View Lumbar Spine. FINDINGS: The appearance of what appears to be T7 is stable from prior plain films and, based on prior MRI, this may be more of a congenital variation in shape of the vertebral body rather than an old compression deformity. No acute fractures or compression deformities otherwise seen through the thoracic or lumbar spine. IMPRESSION: There is a prominent right transverse process of L5 that creates a pseudoarthrosis with the right sacral ala, which can be symptomatic in some patients on a chronic basis. Normal overall alignment evident.

The claimant was re-evaluated by MD for 7/10 moderate pain in the mid back. On examination, he had normal sensation and motor strength. TREATMENT PLAN: Will schedule MRI. He was taken off work pending MRI.

UR performed by MD. REVIEWER COMMENTS: The medical report indicates that the patient has thoracic spine pain. On physical examination, there is point tenderness on the thoracic and lumbar spine. There is decreased thoracic spine range of motion. There is normal strength, intact sensation, and normal DTRs. This is a request for MRI of the thoracic spine without contrast. However, the clear rationale for the requested MRI was not mentioned. The medical information submitted for review does not indicate any presence of red flags, thoracic radiculopathy, or severe or progressive neurologic deficits to warrant the medical necessity of the imaging modality. Moreover, the medical report failed to objectively document exhaustion of conservative care such as oral pharmacotherapy and Physical Therapy. Recent Physical Therapy notes that show the functional response of the patient were not submitted. In addition, there are no noted medication reviews with Visual Analog pain scales to indicate optimized pharmacotherapy. Hence, the medical necessity of this request has not been facilitated.

UR performed by DO. REVIEWER COMMENTS: This is an appeal for a thoracic MRI. The previous request was non-certified due to lack of a clear rationale for the requested study, no documentation of red flags, thoracic radiculopathy, or severe or progressive neurologic deficits, and no documentation of exhaustion of conservative care. Updated documentation elaborates that the patient has

attended 14 PT sessions with good progress. The latest medical report noted that the patient presented with moderate pain over the mid back. The physical exam showed normal sensation and motor strength. There was still no documentation of objective findings suggestive of any neurological pathology. Furthermore, there was still no indication that these findings point to progression or worsening of the patient's condition to warrant the requested study. It was also referenced in the radiology report that the patient has apparently had prior MRI. Hence, the previous non-certification is upheld.

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

The previous adverse decisions are upheld. The claimant is a male who injured his mid and upper back when he was struck in his head at work, and his neck was hyperextended. To date he has received 14 therapy treatments with good response but continues to complain of focal pain in the mid back region. There is no documentation of pharmacological remedies that have been tried to control his pain. Prior imaging studies have not shown neurological impingement in the thoracic spine. Physical exam does not reveal any neuromotor progression of signs or symptoms that would warrant surgical candidacy. ODG/ back/ criteria for imaging are as listed below. At present time, claimant does not meet these criteria. Therefore medical necessity for repeat imaging studies has not been demonstrated and I am not endorsing this request for MRI Thoracic Spine W/O Contrast 72146.

ODG:

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| <p>MRIs (magnetic resonance imaging)</p> | <p><u>Indications for imaging -- Magnetic resonance imaging:</u></p> <ul style="list-style-type: none"> - 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. - 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 |
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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)**