

MATUTECH, INC.

PO BOX 310069
NEW BRAUNFELS, TX 78131
PHONE: 800-929-9078
FAX: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: December 30, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI lumbar spine with and without contrast

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

Certified, American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI:

- Utilization reviews (10/17/11, 11/17/11)

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- Diagnostics (01/25/05, 01/04/10)
- Office visits (01/11/08 – 11/03/11)
- Utilization reviews (10/17/11, 11/17/11)

Dr.:

- Office visits (01/11/08 – 10/31/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his lower back on xx/xx/xx, after he lifted and rotated a 55-gallon trashcan at work. He felt a tear followed by immediate pain in his lower back.

PRE-INJURY RECORDS: On January 25, 2005, magnetic resonance imaging (MRI) of the lumbar spine was performed. The findings were as follows: (1)

Degenerative disc disease (DDD) at L4-L5 and L5-S1 with broad-based posterior disc bulges but no focal disc protrusions. (2) Lateral disc bulges into the inferior aspect of the neural foramina at L4-L5 and L5-S1 bilaterally with mild impingement on the exiting nerve roots.

POST-INJURY RECORDS

2008: On January 11, 2008, M.D., evaluated the patient for lumbar pain. The patient had undergone physical therapy (PT) and chiropractic treatment, which did not provide any relief. Examination revealed pain with forward flexion, extension from a forward flexion position, extension, right rotation and left rotation. X-rays of the lumbar spine showed arthropathy of the bilateral L5-S1 facets. Dr. diagnosed lumbago and lumbar radiculopathy; prescribed Neurontin; restricted him from heavy lifting and recommended application of ice and heat to the affected area, and weight loss. He opined that if conservative treatment failed then surgical intervention could be considered.

In the following visit, Dr. noted that transcutaneous electrical nerve stimulation (TENS) unit helped the pain. Patient presented with bilateral lower extremity electrical shooting pain, numbness and tingling which radiated from buttock to the posterior thigh and into the posterior lateral calf and sometimes to the plantar aspect of the feet. Dr. performed an epidural steroid injection (ESI) at the right L4-L5 level. This was followed by another ESI at the L4-L5 level with epidurogram on February 26, 2008.

In March, the patient reported that the ESI in February did not help and he continued to have sharp shooting lumbar pain. Examination revealed that the lumbar spine had a guarded range of motion (ROM) secondary to stiffness and pain that exacerbated on flexion and bilateral rotation. The lower extremities showed positive bilateral straight leg raise (SLR) test. Dr. noted that Neurontin had helped relieve some of the radicular symptoms and continued use of the same. In May, Dr. noted that the patient had been given maximum medical improvement (MMI) even though he was not at MMI.

On August 12, 2008, lumbar discogram was performed which revealed posterior annular tear at the L3-L4, L4-L5 and L5-S1 levels. In follow-ups, Dr. noted that patient went to an emergency room (ER) because of the low back pain. Examination revealed tenderness to palpation in the lumbosacral facets. He prescribed Norgesic and Neurontin. On October 23, 2008, Dr. performed bilateral facet injections at the L3-L4, L4-L5 and L5-S1 levels.

2009: On January 19, 2009, Dr. noted that the patient continued to have lumbar pain with few incidents of giving way of his legs. The patient had difficulty performing his regular activities of daily living (ADL). Dr. Urrea noted that the previously requested intradiscal electrothermal therapy (IDET) of different discs had been denied. He opined that surgical procedures should help with these multiple level discogenic pain, patient should continue the use of proper body mechanics, avoiding heavy lifting. The patient was treated with Neurontin, Ultram and Soma.

On August 5, 2009, Dr. noted that the patient had undergone coronary artery bypass grafting (CABG) and was under cardiac rehabilitation. For lumbar pain,

the patient took Cymbalta, Soma and tramadol. Dr. assessed lumbar disc derangement and recommended magnetic resonance imaging (MRI) of the lumbar spine.

2010: From January through October, Dr. saw the patient for significant increased low back pain along with fatigue and weakness of his legs. The patient used a Roll-Aid to walk with. Dr. reviewed the previous MRI dated January 25, 2005, that showed broad disc bulges at L4-L5 and L5-S1. The patient had significant worsening neurological status with neurogenic claudication. Dr. opined that the patient had failed conservative treatment, prescribed Neurontin, Ultram, Lortab and Lyrica and recommended PT.

On January 25, 2010, MRI of the lumbar spine showed: L1-L2: facet arthrosis with mild canal stenosis. L2-L3: facet arthrosis and ligamentum flavum hypertrophy with osteophytic ridging and disc bulging that produced mild canal stenosis. Far laterally in the neural foramen on the left, was a 9-mm disc protrusion, which further impinged on the neural foramen. L3-L4: facet arthrosis with facet gapping and ligamentum flavum hypertrophy. There was osteophytic ridging and disc bulging with moderately severe foraminal stenosis and moderate canal stenosis. L4-L5: facet arthrosis and ligamentum flavum hypertrophy with osteophytic ridging and disc bulging producing moderate canal and moderately severe foraminal stenosis. L5-S1: facet arthrosis and disc bulging with moderate canal stenosis. Impression: Bilateral disc protrusions at L2-L3 on the left, multifactorial changes including congenitally short pedicles producing moderate to moderately severe canal and foraminal stenoses from L3-L4 through L5-S1.

In March, Dr. requested post lumbar decompression from L2 to S1, which had been delayed due to pending clearance from Dr., cardiologist, as the patient had abnormal EKG.

On August 5, 2010, the patient had left L5-S1 epidural injection with epidurogram performed by Dr..

On August 30, 2010, the patient had partial laminectomy at L2 with laminectomies at L3, L4, L5 and S1 levels.

On November 3, 2010, the patient had PT evaluation with the plan of 3 PT sessions a week for four weeks.

2011: From January through September, Dr. evaluated the patient for lumbar pain and advised the patient to lose weight. Dr. opined that the patient had increased lumbar pain that was facetogenic and needed lumbar facet block which was denied. The patient was treated conservatively with medications.

Per utilization review dated October 17, 2011, the request for lumbar MRI was denied with the following rationale: *"The patient who sustained an injury on xx/xx/xx continues to complain of increased lumbar pain. According to last clinical note the patient was noted to have tingling sensation on both anterior lower legs on light touch sensation and was noted to have L2-L3 radiculopathy. There is no other clinical documentation available to support these findings. The patient was also recommended for a left L2-L3 transforaminal epidural injection although it is not documented the patient has received the injection. Official*

Disability Guidelines recommend a repeat MRI should be reserved for a significant change in symptoms & for findings suggestive of significant pathology (e.g., tumor, Infection, fracture, neural compression, recurrent disc herniation). Although the patient has continued to have increased lumbar pain & tingling sensation to both anterior lower legs, there is no indication of a significant change in symptoms and/or finding suggestive of significant pathology.”

On October 31, 2011, Dr. evaluated the patient for recurrent lumbar pain with lower extremity radicular symptoms along with pain, numbness and tingling with few incidents of legs giving way. Dr. submitted a reconsideration request for the lumbar MRI.

Per reconsideration review dated November 17, 2011, the request for lumbar MRI was denied with the following rationale” *“This is a male who was injured on xx/xx/xx The claimant has had Imaging documenting lumbar spondylosis for which he had undergo lower levels of care including bilateral facet injections October 23, 2008. The claimant was diagnosed with low back pain, lumbar radiculopathy and lumbar spinal canal stenosis at that time. The claimant does not document evidence of radiculopathy on physical examination or changes in physical examination to warrant repeat Imaging per guideline recommendations. Guidelines indicate repeat imaging should be reserved for evidence of neurological deficits, changes in symptoms and physical examination findings and symptoms consistent with neurological deficits or significant pathology.”*

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

ODG requires *objective* evidence of a substantial progressive neurologic deficit in order to consider a repeat MRI medically reasonable and necessary. It does not appear that sufficient objective clinical evidence of worsening or progression of neurologic findings has been produced.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES