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Notice of Independent Review Decision

Date: July 11, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of lumbar spine with and without contrast 72518

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

Summary of qualifications: Medical Doctorate (M.D.) degree from the University of Kentucky College of Medicine, Lexington, Kentucky; residency in physical medicine and rehabilitation at the University of Kentucky; and at least 14 years of experience actively and continually practicing physical medicine and rehabilitation and producing Peer Reviews and other expert opinion supported by evidence-based medical literature, guidelines, and standards-of-care. Active and unrestricted Texas license has been maintained. Certified by the American Board of Physical Medicine and Rehabilitation, 1999. I have extensive experience with worker's compensation claims in Texas. I have received training and possess significant experience in the use of the *ODG* and the *Guides to the Evaluation of Permanent Impairment*, AMA.

REVIEW OUTCOME:

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

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 (05/15/12 – 06/12/12)

Healthcare

- Office visits (09/28/09 – 05/07/12)
- Reviews (09/02/09 - 07/27/11)
- Diagnostics (04/03/01 - 05/10/12)

CNA

- Office visits (12/02/03)
- Diagnostics (12/17/03 - 05/10/12)
- Procedure (12/17/03, 03/08/05)
- Therapy (12/17/03, 02/04/04)
- Reviews (03/05/07, 06/13/08, 09/02/09)

- Utilization reviews (05/15/12, 06/12/12, 06/27/12)

M.D.

- Diagnostics (04/03/01 - 07/05/10)
- Office visits (09/28/09 - 05/07/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who on xx/xx/xx, was loading materials for the kitchen and developed lower back pain due lifting and bending.

In April 2001, magnetic resonance imaging (MRI) of the lumbar spine showed partial lumbarization of S1 and sclerotic pseudoarticulation in the right sacral ala related to that partial lumbarization.

In May 2002, M.D., noted that the patient had more pain going down her legs, especially the left leg. Examination showed decreased pinprick sensation in an L5 distribution on the right, slightly decreased on the left and tenderness bilaterally in the lumbosacral regions. Dr. assessed lumbar postlaminectomy syndrome and chronic lower extremity radiculopathy. The patient was maintained on Duragesic patches. Dr. recommended MRI, electrodiagnostic studies, laboratory tests and activity as tolerated.

In December 2003, M.D. noted that the patient had incapacitating back pain. He performed anterior lumbar interbody fusion at L5-S1 using a Synthes spacer graft packed with BMP.

From February 2004 through January 2005, the patient attended multiple sessions of skilled rehabilitative therapy consisting of hot packs, interferential stimulation and aquatic activities.

In April and October 2004, Dr. noted that she had some left radicular pain after a recent motor vehicle accident (MVA). Examination showed some tenderness posteriorly. She responded well to a Decadron Dosepak.

X-rays of the lumbar spine showed pedicle screws and posterior fusion plates at L5-S1, bony graft material showing incomplete union held in place by an anterior compression screw. A grade I anterior listhesis of L5 on S1.

From May through December 2004, the patient was under the care of Dr. for complaints of back pain going across the buttock, occasionally into the left leg and occasional left leg stabbing pain. Dr. maintained the patient on Remeron, methadone, Neurontin, activities as tolerated and therapy. It was noted that the patient had been diagnosed with breast cancer and had a partial mastectomy and she was undergoing chemotherapy.

In October, Dr. noted that the patient was recovering nicely from radiation/chemotherapy for her breast cancer. X-rays of the lumbar spine showed postoperative changes.

2005: From February 2005 through September 2006, the patient was under the care of Dr. for ongoing bilateral low back pain and leg pain. She had difficulty doing downstairs and balance problems. Dr. maintained her on nortriptyline, methadone and Neurontin, Duragesic patches and Skelaxin.

In March, the patient had bilateral sacroiliac (SI) joint injections. She reported that injection helped her for several days.

In May, Dr. changed her medication from methadone to fentanyl patches. X-rays showed evidence of posterior L5 laminectomy with fusion and approximately 5 mm of L5 anterolisthesis on S1.

2006 – 2008: From April 2006 through December 2008, the patient had regular follow-ups with Dr. for complaints postlaminectomy syndrome with residual lower extremity radiculopathy. She continued to utilize Duragesic patches, Lyrica, Norco, Cymbalta and quad cane.

In September 2006, x-rays of the lumbar spine showed metallic hardware extending posterolaterally from L2 to L5 and moderate retrolisthesis of L5 upon L3-L4. MRI of the lumbar spine revealed postoperative changes at L4-L5 without evidence of recurrent disc herniation or significant postoperative complication.

In December 2006, Dr. noted that the patient had balance problems and falling on two occasions. He recommended trigger point injections (TPI) in the hardware area to consider possible hardware removal. However, the request was denied.

In March 2007, M.D., performed a peer review and rendered the following opinions: The patient's compensable injury correlated with a chronic lumbar strain. The degenerative changes with concordant pain at L5-S1 were not related to the work injury. If the surgery was accepted as part of the compensable injury as well as the disc herniation at L5-S1, then the ongoing complaints would be related to the occurrence and failed line of treatment. Referral to a spine surgeon, flexion and extension films, possible bone scan with computerized tomography (CT) myelogram, continued pain management, comprehensive pain program was reasonable with monthly or quarterly office visits. There was no indication for further PT. Duragesic and Lyrica were reasonable medications and did not require weaning. The injury apparently had not resolved, as the patient remained symptomatic as it relates to her back surgery from 2003. Dr. noted the following history: *On February 16, 2001, M.D., performed a required medical evaluation (RME) and opined that the patient was not at maximum medical improvement (MMI). On May 18, 2001, Dr. assessed MMI as of April 19, 2001, with 6% impairment rating (IR). On August 15, 2002, and October 2, 2002, the patient had lumbar ESI performed by Dr. In an amended designated doctor report, M.D., dated May 21, 2003, assessed statutory MMI as of June 13, 2002, with 11% IR."*

In September 2007, the patient reported that she had some gallbladder problems, hematuria and she was utilizing Cymbalta, Nexium and Arimidex.

On June 13, 2008, M.D., evaluated the patient and reviewed the medical records. He rendered the following opinions: The treatment to that date and ongoing prescription medications were per ODG criteria. Future treatments including office visits every four months and a quad cane were reasonable. The only diagnostic indicated would be a local block of her metallic implants to see if they were causing her pain posteriorly and if removal of the metallic implant might be helpful. There were no indications for any type of therapy except HEP.

2009 – 2010: From March 2009 through May 2010, Dr. refilled Lyrica, Cymbalta and Ultram. He gradually decreased Duragesic patches and Norco and then finally discontinued it.

On September 2, 2009, M.D. performed a required medical evaluation (RME) and rendered the following opinions: (1) The patients' present status was status post fusion at L5-S1 with continued subjective symptoms. She was also status post breast cancer treatment, apparently a diagnosis of neuropathy. (2) The treatment that the patient had received in the recent past had been related to her lumbar spine injury. She had been treated predominately with pain management to help lessen her discomfort and improve her overall activity level. (3) The surgery approved was related to the injury. (4) The use of medication was in line with the ODG back in 2008. (5) The patient needed to be taken off opioid medications and trying her on just non-narcotic medications. The opioids should be gradually weaned off by 10% every week. The use of Lyrica should also be weaned off. (6) The use of Lyrica and Cymbalta was not helpful. (7) The patient should be placed on a home exercise program (HEP) and try to maintain her cardiovascular fitness and try to improve overall body fitness as well. (8) No further treatment other than weaning off the narcotic medications would be required. No additional PT or referrals would be required. (9) The patient continued to complain of subjective symptoms in her lower back, none of which have been substantially relieved by the treatment.

On July 5, 2010, MRI of the lumbar spine showed surgical changes at L5-S1 and minimal antral listhesis of L5 on S1.

In November 2010, Dr. refilled Cymbalta, Lyrica and Ultram and recommended starting Fentanyl patches.

2011 – 2012: In May 2011, Dr. noted the patient had fallen four to five times in the past year and a half and during that the complaints got exacerbated. Dr. refilled Cymbalta, Lyrica and Ultram.

On July 27, 2011, M.D., performed an RME and rendered the following opinions: (1) The follow-up visits with Dr. had been appropriate particularly for weaning off the Fentanyl and also continued management of the Cymbalta and Lyrica. These

had been related to the original compensable injury. (2) The patient would not require any additional diagnostic testing as she already had an MRI scan in July 2010 that did not show any significant changes. Any additional injections and PT would not be recommended. (3) Current medications and follow-up with Dr. would be needed and recommended.

In September 2011, Dr. refilled Cymbalta, Ultram and Lyrica.

In January 2012, the patient reported her pain was not nearly as well controlled as it was when she was on the Fentanyl patches. Dr. refilled Cymbalta, Ultram and Lyrica and added Duragesic patches.

In March 2012, Dr. noted the patient was doing better than when she was not on the medication. Dr. maintained the patient on Duragesic patches.

On May 7, 2012, Dr. noted the Duragesic patches helped the patient and she was able to function around the house, but was noticing more pain going down her legs, especially the left leg. Examination showed decreased motor strength in the right ankle on dorsiflexion and plantar flexion. There was decreased pinprick sensation in an L5 distribution on the right. There was tenderness bilaterally in the lumbosacral regions without masses or spasms. Reflexes in the knees and ankles were found to be at 0/4. Dr. refilled Duragesic patches and recommended MRI of the lumbar spine.

On May 10, 2012, a urine drug screen was carried out that was found to be positive for Fentanyl, nor-fentanyl and pregabalin.

Per utilization review dated May 15, 2012, the request for an MRI of the lumbar spine with and without contrast was denied with the following rationale: *“The progress note dated May 7, 2012, documents more pain going down her legs, especially the left leg. Exam indicates she has motor strength 4-/5 right ankle dorsiflexion and plantar flexion, other areas 5/5. She has decreased sensation to pinprick in the L5 distribution on the right, slightly decreased on the left. Reflexes were 0/4 knees and ankles. Tenderness is noted bilaterally in the lumbosacral region without masses or spasms. MRI of the lumbar spine with and without contrast has been requested. The patient has been diagnosed with postlaminectomy syndrome. She has ongoing symptoms and findings of lumbar radiculopathy. However, it doesn't appear that the patient's findings have changed significantly over the last one year. The patient's sensory and motor deficits have remained more or less unchanged. Repeat MRI is usually recommended if there is significant change or worsening of the symptoms and/or worsening or new-onset deficits. It should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g. tumor, infection, fracture, neural compression, recurrent disc herniation). The necessity of the request is not established.”*

Per reconsideration review dated June 12, 2012, the request for an MRI of the lumbar spine with and without contrast was denied with the following rationale: *“The original decision indicated that there did not appear to be significant change in the patient’s findings over the last year. The patient reported injury on xx/xx/xx, and now has complaints of low back pain with radiation down her legs, left greater than right. Official Disability Guidelines state MRI may be recommended in patients with severe progressive neurologic deficits from lumbar disc herniation or patients with lumbar radiculopathy who do not respond, to initial appropriate conservative care. Guidelines also state repeat MRI is not routinely recommended and should be reserved for a significant change in the patient’s symptoms or findings suggestive of significant pathology. The documentation provided indicated the patient had complaints of low back pain with radiation into the bilateral lower extremities. The documentation also indicated the patient had 4-/5 strength in the right ankle in dorsiflexion and plantar flexion and decreased sensation to pinprick in the L5 distribution on the right and slightly decreased on the left. However, there is insufficient documentation to indicate the need of an MRI of the lumbar spine at this time. As the patient did not rate her pain on the VAS or indicate functional deficits, she was currently experiencing. Additionally, the patient reported the Duragesic patch allowed her to function around the house. Additionally, there was insufficient documentation to indicate recent conservative treatments initiated to include physical therapy, home exercise program or activity modification and efficacy in terms of reducing the patient’s pain and increasing function. Furthermore, guidelines state repeat MRIs should be reserved for a significant change in the patient’s symptoms and there is insufficient documentation to indicate that there has been a significant change in the patient’s symptomatology that would warrant a repeat MRI. Given the above information, the request for a repeat MRI of the lumbar spine with and without contrast cannot be substantiated at this time and is therefore, non-certified.”*

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

Treatment notes indicate a history of RLE weakness and sensory changes as early as 6-25-09 which was before the most recent MRI of the lumbar spine in 2010. Documentation does not demonstrate acute focal neurological deterioration to support the need of a repeat MRI to the lumbar spine. The injured worker has a long history of LBP with BLE radicular pain with findings of lower extremity weakness and sensory changes. Request not supported by ODG Guidelines.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
Per ODG Guidelines:

Guidelines also state repeat MRI is not routinely recommended and should be reserved for a significant change in the patient’s symptoms or findings suggestive of significant pathology.