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Notice of Independent Review Decision

DATE OF REVIEW: April 30, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI spinal canal without and with contrast (72158)

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

American Board of Neurological Surgery

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 (3/12/12 – 3/27/12)
- Diagnostics (1/04/11)
- Review (2/20/11)
- Office visits (5/10/11 – 2/27/12)
- Utilization reviews (3/12/12 – 3/27/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured at work on xx/xx/xx, allegedly doing lifting of desks, chairs, and boxes to his classroom when his back began to hurt. However, the subsequent records indicate that the patient actually had a work incident in March of that year doing waxing and cleaning of the floor when it fell onto his leg.

On January 4, 2011, the patient underwent magnetic resonance imaging (MRI) of the lumbar spine. The indications for the study were lumbosacral radiculopathy

with adhesions and chronic pain syndrome. The findings were: posterior central and left paracentral disc protrusion measuring 4.44 mm at L2-L3 with thecal sac impingement and mild central spinal canal narrowing, posterior central disc bulge at L1-L2, posterior central mild disc protrusion at L4-L5, postsurgical changes of interbody fusion with interbody fusion device and pedicle screws at L3 and L4.

On February 20, 2011, M.D., performed a peer review. The following records are available:

2000: *The initial records for review were from xx/xx/xx, which showed left knee two views with a history of left knee arthritis. The impression was normal exam. The patient had a lumbar spine series taken on August 7, 2000, showing disc space narrowing at L3-L4 with anterior spurs.*

M.D., evaluated the patient. He noted that the patient had lumbosacral spine pain radiating to the right lower extremity. The patient was noted on physical exam to have decreased sensation at the right L5 and there was also decreased range of motion (ROM). He was taken off duty.

Magnetic resonance imaging (MRI) of the lumbar spine was done at MRI on September 5, 2000, showed loss of normal signal with mild central paracentral disc bulge at L3-L4.

The patient was reported on xx/xx/xx, to have weakness in the dorsiflexion of the right foot, 4+/5. Dr. diagnosis was lumbosacral radiculopathy with bulging disc at L3-L4. He proposed physical therapy (PT), Lortab, and light duty. An RS stimulator was prescribed.

Epidural steroid injection (ESI) was completed on October 12, 2000.

The patient then had a myelogram CT scan performed. This was interpreted by Dr. to show spinal stenosis at L3-L4 and L4-L5 with disc protrusion versus herniation at the same level. The official report, however, from Baptist Medical Center regarding the post myelogram lumbar CT scan indicated that L3-L4 only showed diffuse disc bulging, no evidence of disc herniation, no evidence of canal stenosis. At L4-L5 there was diffuse disc bulging with minimal hypertrophy of the ligamentum flavum and mild canal stenosis.

2001: *A discogram was completed on January 20, 2001, at Health System. At L3-L4, there was noted to be decreased resistance to the injection and the patient had severe pain into the back, into the lower extremities, more to the right than the left. The injection at L4-L5 demonstrated normal resistance to the injection and the patient had no pain.*

On March 27, 2001, the patient had a nerve conduction study (NCS) completed which allegedly showed radiculopathy. However, this result appeared to be based on a CPT threshold test.

On April 11, 2001, the patient had an L3-L4 discectomy and interbody fusion utilizing Allomatrix and Brantigan cages. Bilateral pedicle fixation was performed as well as intertransverse spinous fusion.

On May 22, 2001, the patient was noted to have pain radiating to the knees and was having difficulty getting up from a seated position. The patient continued to be symptomatic and was started on Neurontin as well as Vicoprofen. The patient was kept off duty.

The patient then consulted Dr. (DO). EMGs were completed showing no signs of acute or chronic motor radiculopathy of the bilateral lower extremities from L2 through S2. A myelogram CT scan was performed. The myelogram was considered to be normal with postsurgical changes noted at L3-L4. The CT scan post-myelogram showed postoperative changes at L3-L4 with mild hypertrophy of the L4-L5 facets. L2-L3 was considered to be relatively normal.

M.D., did a carrier-selected RME. He assessed the patient to be at maximum medical improvement (MMI) and gave a 5% impairment rating.

2002: *The patient was followed essentially monthly by Dr.*

Dr. did a designated doctor examination (DDE) and placed the patient at MMI as of March 13, 2002, with a 10% impairment rating.

Dr. performed a combination of trigger point injections (TPIs) of the low back region followed by an SI joint injection on the left.

Physical therapy (PT) was instituted at San Antonio Therapy. This included aquatic therapy. The patient also had therapy active exercise regimens at Therapy through much of late 2002 and then subsequently underwent a work hardening program (WHP). MRI of the lumbar spine was completed at MRI and noted to show mild posterior central disc protrusion at L2-L3 as well as postoperative changes of L3-L4. Dr. performed a needle EMG and NCS and noted that the patient had chronic bilateral L4 motor radiculopathy.

2004: At the Physical Evaluation and Impairment Center, Dr. DC) did some type of evaluation. The basis for his evaluation is not fully explained except it was listed as an Independent Medical Examination.

AP and lateral x-rays with flexion and extension were completed on March 25, 2004, showing partial articulation of the transverse process of L5 which was a developmental abnormality. Flexion, extension views demonstrated no instability at the L3-L4 level which was fused. There was noted movement at L4-L5, L5-S1 and also at L2-L3.

A repeat electrodiagnostic study was done by Dr showing findings of chronic bilateral L4 motor radiculopathy.

A functional capacity examination (FCE) was completed in June at Therapy. This showed the patient was capable of performing the light-medium category of work.

An MRI of the lumbar spine at Southwest Open MRI was completed showing posterior central disc protrusion, minimal thecal sac impingement at L2-L3 without noted interval change as well as postsurgical changes of the L3-L4 fusion without interval change.

Dr. did not provide any further insight as to the rationale for the patient's being kept off work except for the patient reporting residual pain as well as residual weakness.

2005 – 2007: The patient was seen by Dr. on March 30, 2005, for a medical evaluation. Dr. opined that there was no new injury.

Dr. continued to follow the patient and noted that the L2-L3 disc was now, by his opinion, a protrusion.

On September 9, 2006, the patient agreed to proceed with a myelogram to rule out herniation.

Individual psychological assessment and sessions were noted as of August 2, 2007.

The patient apparently attended a pain management program at Injury Rehabilitation in the late 2007 timeframe.

2008 – 2009: The patient's care was further provided by Dr. who had seen the patient previously in July 2007. He noted the patient's current medications of Ambien, Ultracet, and Neurontin.

Dr. reassessed the patient and ordered Motrin, Ultracet, and Ambien.

Spinal cord stimulation (SCS) was discussed by Dr.. However, the patient was to have knee surgery with Dr..

On October 16, 2008, Dr. noted that the patient was having shooting pain with numbness and tingling and he was unable to walk well because of the pain. Dr. advised the patient to have a right knee replacement and that the pain in the left knee was also reportedly getting worse as well.

Dr. noted that the patient had a previous MRI of the left knee showing a partial tear of the posterior cruciate ligament (PCL). The MRI of the right knee showed a focal full-thickness articular cartilage defect over the distal femoral condyle.

On November 11, 2008, Dr. noted that the patient would be offered a transforaminal ESI at L4-L5 and L5-S1. The ESI apparently was denied.

On May 19, 2009, Dr. prescribed further medication of Ambien and the patient was kept off-duty.

2010: On February 9, 2010, the patient reported pain of 8-9 on a 10 scale in the low back with radiation to the extremities.

On July 7, 2010, the patient was noted to have continued symptoms. No new neurological changes were noted.

On October 13, 2010, Dr. proposed a MRI of the lumbar spine, EMG nerve conduction of the lower extremity, as well as x-rays with flexion, extension, as well as medication refills.

Prescription billings from 2004 through 2010 documented the use of the Ambien per prescription of Dr. as well as tramadol.

Dr. rendered the following opinions: The MRI of January 4, 2011, showed a disc bulge/protrusion at L2-L3. However, this would not need surgical intervention. Also the study did not correlate with his EMG findings of chronic L4-L5 radiculopathy. There was no need for further EMG/NCS. He would only need diagnostic testing or imaging of the spine if he were to develop objective neurological changes. The patient should be weaned to an over-the-counter regimen. Ambien and Ultracet should be weaned over every four weeks.

On May 10, 2011, M.D., evaluated the patient in follow-up for low back pain radiating to the lower extremities down to the feet with a pain level of 10+/10. Ultracet helped him control the pain. Examination showed decreased lumbar ROM with mild spasms, decreased but equal deep tendon reflexes (DTRs), decreased sensation at L3-L4 and L4-L5 bilaterally and positive straight leg raise (SLR) test at 40 degrees right. The diagnoses were lumbosacral radiculopathy, protruded herniated disc at L2-L3, thecal sac impingement and injury to both knees. He recommended EMG/NCV of the lower extremities, ESI at the lumbosacral spine and continued off work status.

In September 2011, the patient returned complaining of persistent low back pain radiating to the lower extremities down to the feet with a pain level of 10/10. He had episodes of falling. Dr. reiterated his recommendations of EMG/NCV study and ESI to the lumbosacral spine.

On February 28, 2012, Dr. noted ongoing pain complaints in the back. The patient reported that he did not want to take too many pills as they were not helping him. He was unable to sleep well due to the pain. He had difficulty walking. Dr. noted the patient had steroid injections to both knees 10 days ago. Exam showed decreased ROM with spasms, decreased DTRs but equal, positive SLR test bilaterally, decreased sensation in the distribution of L5-S1 nerve roots bilaterally. Calf circumference was 38.5 cm left and 39 cm right. Dr. ordered MRI of the lumbosacral spine with and without enhancement as well as an EMG/NCV of the lower extremities.

Per utilization review dated March 12, 2012, the request for MRI lumbar spine without contrast was denied with the following rationale: *“Based on the medical records submitted for review on the above referenced claimant, repeat lumbar MRI is not approved. There is no indication for repeat lumbar MRI based on previous lumbar MRI findings and/or physical exam findings. His pain level as remained about the same, along with his physical exam findings since at least May 2011.”*

On May 27, 2012, the appeal for MRI spinal canal with contrast was non-authorized with the following rationale: *“Records document chronic pain with complaints of radicular symptoms and reported sensory deficits. Last MRI was January 2011. I compared January 3, 2011, and recent February 28, 2012, exams. The findings are exactly the same. Interval records also document similar presentation. The ODG criteria of significant change in presentation and progressive deficits are not met.”*

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

Mr. is a gentleman born in, who injured himself in.

He has had all sorts of workup and in fact had a surgery at L3-L4 and L4-L5 with a discectomy, interbody fusion with the cages, Brantigan cages and pedicle screw fixation on April 11, 2001, I think by Dr..

He has had numerous studies and continues to have difficulty. He has had pain and multiple studies including MRI, myelogram, CTs and EMGs had performed.

Currently, Dr. is still seeing this patient and wishes to do another EMG and MRI of the lumbar spine with and without enhancement.

The review panel did not feel that this was indicated as he has had that before and there is really no change in his condition.

Neurologically the gentleman has been stable with complaints of pain. He does not have objective findings but basically has stable neurological changes that have been present for many years.

It my impression that the decision should be upheld. There is nothing new on these medical records which would suggest that there is any change in the patient's condition to warrant him the repeat study as they have been repeated numerous times over the last several years.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES