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## Notice of Independent Review Decision

**Date: October 22, 2012**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

MRI lumbar spine with contrast

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

Fellow American Academy of Orthopaedic Surgeons

**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:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who slipped on a wet floor and nearly fell. He grabbed onto a rail and prevented his fall. Later, he noted that he could not get up from a sitting position due to severe low back pain.

Per Notice of Employee's Work-Related Injury/Illness the patient sustained back injury due to a fall.

The patient was evaluated by a PA-C for pain in the lower back. It was noted that the patient was seen by Dr. X-rays of the lumbar spine had shown osteoarthritis. He was treated with Flexeril and Decadron. Examination showed disability/discomfort on sitting. The PA-C assessed lower back strain, prescribed ibuprofen and Amrix and recommended continuing Flexeril and use of heating pads.

On follow-ups, the patient was evaluated M.D., and the PA-C for pain in his lower back and radiculopathy symptoms. Examination showed mild tenderness of the lumbar spine and right sacroiliac (SI) joint, inability to sit on chair and burning sensation in the back. The patient was maintained on medications and was recommended physical therapy (PT) and magnetic resonance imaging (MRI) of the lumbar spine.

On December 28, 2010, MRI of the lumbar spine showed right paracentral disc protrusion at L5-S1 causing right lateral recess narrowing and displacement of the thecal sac and descending nerve roots with proximal right neuroforaminal narrowing. Left neuroforaminal narrowing from foraminal disc protrusions was seen at L3-L4 and L4-L5.

X-rays of the lumbar spine revealed degenerative disc disease (DDD) with mild disc space narrowing at L5-S1.

**2011:** In January, Dr. reviewed the MRI and x-rays findings and referred the patient to an orthopedic surgeon. The patient was maintained on hydrocodone/APAP.

An orthopedic surgeon, evaluated the patient for pain in his back and left lower extremity. Examination of the lumbar spine showed mild paravertebral muscle spasm, possible extensor lag, positive spring test at L5-S1, possible sciatic notch tenderness on the left only, positive flip test on the left, possible Lasegue's at 45 degrees, positive Bragard's, absent posterior tibial tendon jerk bilaterally, decreased ankle jerk on the left, weakness of gastroc-soleus, and paresthesia of L5 and S1 nerve root distribution on the left. He obtained x-rays of the lumbar spine and x-rays of the pelvis. X-rays of the lumbar spine showed anterior column lack of support with clinical instability with a normal measuring 13 mm L5-S1 measuring 4 mm for a total deficit of 9 mm; anterior column lack of support associated with facet subluxation, foraminal stenosis, and lateral recess stenosis with posterior column lack of support. X-rays of the pelvis was normal. Dr. assessed herniated nucleus pulposus (HNP) at L5-S1, traumatic in nature with clinical instability and failure of conservative treatment. He recommended PT and exercise program.

From January 20, 2011, through February 25, 2011, the patient attended 10 sessions of PT consisting of hot packs and therapeutic activities.

In February, the patient was seen for ongoing back complaints and left leg pain. Diagnoses were herniated disc and degenerative disc disease (DDD). The patient was treated with intramuscular (IM) injection of Kenalog and was LHL602.

maintained on ibuprofen and tramadol.

On February 22, 2011, Dr. noted that the patient had ongoing pain in his back and left leg. The patient had little improvement with PT. Dr. assessed traumatic lumbar HNP with clinical instability and equivocal response to conservative treatment and recommended continuing PT.

In March, Dr. noted that the patient remained extremely symptomatic with back pain, leg pain and leg weakness. He assessed HNP at L5-S1 with clinical instability and failure of conservative treatment with lower extremity radiculopathy and weakness and recommended continuing medication and surgical intervention.

Dr. also opined that the patient needed surgical intervention for his ongoing complaints.

On March 30, 2011, M.D., performed electromyography/nerve conduction velocity (EMG/NCV) study of the lower extremities which showed an indication of mild acute L5 and S1 radiculopathy with the S1 root being more involved on the left

with no apparent involvement of the L2, L3 or L4 roots. The right peroneal F-wave was slightly delayed though despite the reduced left ankle jerk, no significant slowing of the tibial H-reflex was identified.

In April, the patient had several follow-ups with Dr. for ongoing significant lower back and left leg pain. Dr. maintained him on medications.

On May 5, 2011, D.O., performed a designated doctor evaluation (DDE) and opined that the patient was not at maximum medical improvement (MMI). The Beck Depression score and Beck Anxiety score showed minimal depression and mild anxiety respectively.

In May and June, the patient had follow-up visits with Dr. It was noted that there was no change in lower back and left leg pain. The patient was maintained on medications and was recommended follow-up with the orthopedic surgeon.

In June, Dr. noted that the patient was no longer willing to live with his ongoing symptomatology and wanted to proceed with surgical intervention. He continued have pain in his back and left leg. Dr. assessed lumbar HNP with clinical instability, L5-S1 with failure of conservative treatment and annular tears, L3-L4 and L4-L5 with no collapse and no symptomatology of nerve root involvement clinically. He recommended decompressive lumbar laminectomy, discectomy and instrumented arthrodesis at L5-S1.

In July, Dr. noted that the patient was awaiting surgical intervention. He recommended continuing medication.

On July 29, 2011, M.Ps., performed a psychological evaluation and assessed adjustment disorder with mixed anxiety and depressed mood secondary to the work injury and pain disorder associated with both psychological factors and a general medical condition. Dr opined that the patient was considered to be a fair risk for the surgical procedure, from a psychological perspective.

From August through November, the patient had regular follow-ups with Dr. for back and leg complains. Dr. noted that the patient was still awaiting surgical intervention. Diagnosis was low back pain, HNP and arthralgia. He maintained the patient on hydrocodone/APAP.

On December 27, 2011, the patient was admitted to Hospital. Per hospital document, Dr. performed decompression at L4-L5-S1. Postoperatively, the patient had mild anemia and leucocytosis and he was treated accordingly. On December 28, 2011, the patient underwent PT evaluation and attended few sessions of gait training.

**2012:** On January 1, 2012, the patient was discharged and was recommended to follow-up with Dr. in two weeks.

On January 17, 2012, Dr. noted that the patient had back stiffness with some numbness and tingling through his left leg. He ambulated without assistive devices and wore a back brace. He was started on Aloe Vera treatment as well as a walking and stretching program. Dr. obtained x-rays of the pelvis which showed hips without degenerative joint disease (DJD) and SI joint without sclerosis or focal findings. X-rays of the lumbar spine showed L4-L5 and L5-S1 decompression, L5-S1 global instrumentation arthrodesis with a cross link in good position with no motion on flexion-extension views and early new bone formation interbody. Dr. assessed status post lumbar spine reconstruction with delay in treatment from injury at one year.

In February, the patient reported pain around his SI joints worse on the right than the left after he experienced a tearing sensation about four weeks ago. Dr. obtained x-rays of the lumbar spine that revealed L5-S1 decompression with global instrumented arthrodesis with cross-link in good position with good new bone formation with no motion on flexion-extension views. There was no evidence of hardware loosening, failure, or adjacent segment disease. Dr. prescribed Naprosyn and recommended aquatic therapy.

In March, Dr. noted the patient had spasms in his lower back. He recommended continuing medication and follow up with orthopedic surgeon.

From March 20, 2012, through May 29, 2012, the patient attended 24 sessions of PT consisting of aquatic therapy, therapeutic exercises and manual therapy.

In May, Dr. noted the patient was utilizing hydrocodone/APAP, tramadol and Naprosyn.

On May 9, 2012, M.D., a pain management specialist, evaluated the patient for pain in his lower back. It was noted that the patient had undergone surgery with some benefit. However, the patient had persistent pain in the lumbar region and pain travelling into the left lower extremity in an S1 dermatomal distribution. The pain was constant throughout the day. Dr. assessed chronic pain syndrome, lumbar disc displacement, failed back syndrome, lumbar radiculopathy, and therapeutic drug monitoring. He prescribed Nucynta, Neurontin, and Zanaflex and allowed him to continue Norco.

On May 10, 2012, urine drug screen was positive for hydrocodone and tramadol.

On May 29, 2012, Dr. obtained x-rays of the pelvis which were unremarkable. X-rays of the lumbar spine showed L5-S1 decompression with global instrumented arthrodesis with a cross-link in good position, well healed with no motion on flexion-extension views no evidence of hardware loosening, failure, or adjacent segment disease. He assessed status post lumbar spine reconstruction with excellent early result and recommended continuing medication and home exercise program (HEP) as well as work hardening program (WHP).

On May 29, 2012, the patient underwent PT re-evaluation. It was noted that he had completed 24 treatments and would now benefit from work conditioning followed by a functional capacity evaluation (FCE).

On May 31, 2012, Dr. noted that the patient had lumbar pain travelling into the left lower extremity stopping at the level of the left knee. The patient had dull pain which was deep inside the thigh region. Dr. recommended discontinuing Neurontin as he had swelling of feet and tingling in the hands. He prescribed Butrans, Norco, Zanaflex and ibuprofen.

On June 26, 2012, Dr. recommended follow-up with orthopedic surgeon and pain management specialist.

On June 27, 2012, the patient underwent an FCE. The evaluator opined that the patient was able to meet all job requirements despite complaint of lower back pain and was able to return to work without restrictions.

On July 5, 2012, the patient reported pain in his lower back after his FCE. He had pain that was occasionally radiating into the anterior and posterior aspects of the left leg. He also reported that the medications were helping. Dr noted that Dr. had recently prescribed zolpidem, tramadol, Zanaflex, Norco, and naproxen. He recommended continuing medication.

On July 24, 2012, Dr. noted that the patient was unable to get out of his bed for two days due to pain in his lower back after his FCE. He obtained x-ray of the hips which were unremarkable. X-rays of the lumbar spine demonstrated L5-S1 decompression with global instrumented arthrodesis with cross-link in good position, well healed with no motion on flexion-extension views, no evidence of hardware loosening failure or adjacent segment disease. Dr. assessed status post lumbar spine reconstruction with excellent early result and referred the patient to Disability and Rehabilitation Services for re-training.

On August 6, 2012, Dr. noted that the patient had ongoing pain and mild improvement with medications. He had achy and throbbing pain which was throughout the day. His activity level remained stable. Examination of the lumbar spine showed decreased range of motion (ROM) and surgical scar. Dr. prescribed Norco, tramadol and Zanaflex.

On August 7, 2012, Dr. noted that the patient had overexerted himself and experienced increase in his low back pain. He was unable to perform all of his activities of daily living (ADLs) if he was not taking any medications. Dr. recommended continuing medications.

On August 9 and August 11, the patient attended PT consisting of therapeutic exercises.

On September 7, 2012, M.D., performed a DDE and assessed clinical MMI with 5% whole person impairment (WPI) rating.

On September 11, 2012, Dr. noted the patient had gone downhill for the last two months. He could only sit or stand approximately for one hour at a time. He was utilizing tramadol and hydrocodone/APAP while awake. He had pain in his shoulders and headache which would not go away. He was concerned that he would be released and his limitation and pain would not be addressed. Examination showed that he walked hunched over and with a slight limp favoring his right leg, mild tenderness over the lumbar spine and paraspinal muscles. Dr. assessed back pain and HNP. He opined that the patient's condition was worsening. He recommended continuing medication and follow-up with Dr. and the Pain Clinic.

On September 18, 2012, Dr. noted the patient ambulated without any assistive devices and he had markedly increased back pain after DDE. He had some radiation into his bilateral legs but not below the knees. Examination of the back and lower extremities revealed well-healed midline incision, marked paravertebral muscle spasm, equivocal extensor lag, positive sciatic notch tenderness, positive flip test bilaterally, possible Lasegue's at 45 degrees and absent posterior tibial tendon jerks. Dr. assessed acute exacerbation of lumbago secondary to forceful manipulation by designated doctor with increase in symptomatology, prescribed Medrol Dosepak and oxazepam for muscle spasm. He recommended continuing hydrocodone and obtaining a gadolinium-enhanced MRI scan to make sure that there was no manipulation of adjacent segment disease at L4-L5.

Per utilization review dated September 25, 2012, the request for outpatient lumbar spine MRI with and without contrast was denied with the following rationale: *"This claimant was injured in Texas. There was a lumbar strain. This is a request for a lumbar MRI. He underwent a laminectomy and fusion with instrumentation on October 26, 2011. The claimant completed twenty-four (24) sessions of physical therapy (PT) and had a bone growth stimulator (BGS). He has not gotten better, and notes increased back pain after the designated doctor examination. X-rays showed good position of the instrumentation. There is no evidence of hardware loosening...Given the metal in place from the fusion, MRI is not the optimal test. At present, the records and the evidence-based citations do not support an authorization of the request."*

Per reconsideration review dated October 4, 2012, the request for outpatient lumbar spine MRI with and without contrast was denied with the following rationale: *"This male was injured when he slipped, but did not fall. The claimant subsequently underwent a lumbar laminectomy and fusion with instrumentation on October 26, 2011, with a bone growth stimulator (BGS) provided and the claimant has completed twenty-four (24) sessions of physical therapy (PT) postoperatively. Dr. evaluated the claimant on September 18, 2012, noting markedly increased back pain after a designated doctor examination (DDE). The claimant reported "not appreciably better to that point" and reported some radiation into the legs*

*bilaterally. X-rays by Dr noted the L5-S1 arthrodesis with hardware in good position and being well-healed and there was no motion on flexion/extension and no evidence of hardware loosening. Physical examination noted paravertebral muscle spasm and equivocal extensor lag sign with sciatic notch tenderness bilaterally. Lasegue's was positive, as was flip test bilaterally. The peer review on September 24, 2012, recommended non-authorization of the MRI noting with metal in place from the fusion, an MR was not the optimal test and the records and evidence-based citations did not support authorization of the request. There has been no further medical information provided since the peer review. Therefore, I agree with the prior peer review; an MRI is not indicated, as there were no findings on the examination supporting the MRI in light of hardware being present from the prior fusion."*

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

I reviewed the documentation and the claimant's last evaluation with Dr. did not document any new neurologic deficit. The claimant has had a lumbar spine fusion with instrumentation making the usefulness of an MRI questionable. Using ODG Guidelines the claimant would have to have a change in neurologic status to warrant a repeat or new MRI scan. Therefore the decision is upheld.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**