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Notice of Independent Review Decision

**Date notice sent to all parties:** 06/19/13

**IRO CASE #:**

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

Lumbar MRI without contrast

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

Board Certified in Orthopedic Surgery  
Fellowship Trained in Spinal Surgery

**REVIEW OUTCOME:**

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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

Lumbar MRI without contrast - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Reports dated 01/17/06, 01/27/06, 02/09/06, 01/11/07, 01/31/07, 02/07/07, 02/28/07, 03/22/07, 06/29/07, 08/09/07, 08/31/07, 10/01/07, 10/31/07, 11/28/07, 12/20/07, 02/04/08, 02/22/08, 03/06/08, 03/31/08, 04/30/08, 05/16/08, 05/28/08, 06/30/08, 07/24/08, 09/24/08, 11/21/08, 01/21/09, 03/02/09, 05/04/09, 07/03/09,

10/08/09, 01/13/10, 03/15/10, 05/19/10, 07/26/10, 11/23/10, 02/23/11, 08/03/11, 12/05/11, 02/08/12, 04/09/12, 04/26/12, 07/09/12, 08/09/12, 11/09/12, 11/28/12, 12/12/12, 02/12/13, and 05/10/13

Employee status report dated 01/17/06

DWC-73 forms dated 01/17/06, 01/27/06, 02/09/06, 01/11/07, 01/31/07, 02/07/07, 02/28/07, 03/22/07, 06/29/07, 08/10/07, 08/31/07, 10/01/07, 10/31/07, 11/28/07, 12/20/07, 02/04/08, 02/22/08, 03/06/08, 03/31/08, 05/28/08, 06/30/08, 07/24/08, 09/24/08, 11/21/08, 01/21/09, 03/02/09, 05/04/09, 07/03/09, 10/08/09, 01/13/10, 03/15/10, 05/19/10, 07/26/10, 11/23/10, 02/23/11, 08/03/11, 12/05/11, 02/08/12, 04/09/12, 04/26/12, 07/09/12, 08/09/12, 11/09/12, 11/28/12, 12/12/12, 02/12/13, and 05/10/13

Lumbar MRIs dated 02/02/07 and 07/02/08

Pathology report and laboratory sheets dated 02/28/07, 02/01/08, 05/04/09, and 01/13/10

Report dated 10/05/07

DWC-69 form dated 06/03/08

Prescription refill requests dated 05/11/09, 11/30/09, 09/06/10, 10/12/10, 11/16/10, 12/20/10, 03/09/11, 03/09/11, 03/12/11, and 05/21/12

CT scans of lumbar spine dated 10/21/10 01/16/12

Scriptwise note dated 01/05/11

Prescriptions for Ultracet dated 02/08/12 and 04/09/12

Notices of Preauthorization Determinations from TASB dated 03/06/12, 04/10/12, 11/15/12, 04/09/13, and 05/13/13

X-rays of the lumbar spine dated 04/26/12 and 05/01/12

Referral dated 07/10/12

Preauthorization requests dated 04/09/13 and 05/10/13

TML Notices of Decision dated 04/12/13 and 05/16/13

Appeal/Reconsideration Letter dated 05/13/13

Prospective Review Response dated 06/04/13

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

examined the patient on 01/17/06. He was injured on 01/13/06 when he was putting a toolbox in the back of a truck and as he completed the lifting he felt the onset of pain over his lower back that he initially described as a pull. However later on in the afternoon and evening the pain became more severe and he developed more stiffness of the lower back. He had no numbness or weakness in the lower extremities or radicular symptoms. He was sitting with his back stiff on examination. Straight leg raising produced pain in the lower back at about 60 degrees bilaterally in the recumbent position. Deep tendon reflexes and neurological examination were intact. There was an area of tenderness along the potential level of L4-L5 extending bilaterally into the iliolumbar regions with palpable spasms. Heel toe gait was intact. X-rays revealed straightening of the lordotic curve indicative of spasms. The assessment was acute lumbosacral spine sprain/strain and spasms. Lodine, Ultracet, and physical therapy were

prescribed and modified duty was recommended. On 01/31/07, reexamined the patient. He had no improvement in his back pain and occasionally radiated to the right buttock. He continued with persistent tenderness over the right paralumbar region of L5-S1 extending into the SI joint and right buttock. An MRI was recommended at that time and his work duties were continued. An MRI of the lumbar spine was obtained on 02/02/07 and revealed a moderate disc bulge at T12-L1 with no stenosis, moderate disc degeneration at L1-L2 with a mild disc bulge and no stenosis, and an essentially normal disc level at L2-L3 and L3-L4. There was no stenosis at L4-L5 with a mild disc bulge and early facet arthritis. At L5-S1, there was no significant disc abnormality. examined the patient for low back and right leg pain on 10/05/07. He had received multiple sessions of physical therapy, which did not improve his pain. He also noted an epidural steroid injection (ESI) did not improve his back or leg pain. His current medications were Etodolac, Tizanidine, Enablex, Nifedipine, Simvastatin, Acyclovir, and Advair. He was six feet one inch tall and weighed 184 pounds. He had tenderness about the midline portion of the lumbar spine and strength was 5/5 in the bilateral lower extremities. He was tender over the right L5-S1 area. The MRI was reviewed. The diagnosis was a lumbar spine herniated disc and a new MRI was recommended at that time. reexamined the patient on 05/28/08 and he continued with lower back pain. It was noted he had an appointment with neurosurgery on 06/17/08. He had right paralumbar area tenderness and painful range of motion. An MRI of the lumbar spine on 07/02/08 revealed no compression fracture or tumor and a Schmorl's node in the endplates of the inferior superior spine and upper lumbar spine. There was degenerative disc narrowing at L1-L2 with a moderately large broad based disc bulge as before, which caused borderline central stenosis, but no further compression. At L2-L3 there was a mild diffuse disc bulge without frank central or foraminal stenosis or neural compression. At L3-L4 and L4-L5 there was a mild diffuse disc bulge with minimal facet spurs and no central or foraminal stenosis. L5-S1 revealed a mild disc bulge with no pars defect or subluxation and no central or foraminal stenosis. On 01/13/10, reexamined the patient. It was noted he was scheduled for an EMG/NCV study and the neurosurgeon had requested a discogram. He continued with tenderness in the right paralumbar area and straight leg raising was negative at 90 degrees bilaterally. His medications were continued. A CT scan of the lumbar spine post discogram on 10/21/10 revealed no large disc protrusion or canal stenosis seen. There were multiple Schmorl's nodes throughout the lumbar spine. continued the patient at full duty on 11/23/10 per a DWC-73 form. reexamined the patient on 08/03/11. He had been on a Fentanyl Patch, felt tired while on medication, and only had mild relief. He had a stimulator for trial, but it could not be adjusted to the lower back. His documented medications were Hydrocodone, Naprelan, Nuvigil, Skelaxin, Fentanyl, Hydrochlorothiazide, and Simvastatin, as well as Tramadol. He was noted to have benign hypertension and hyperlipidemia. He had tenderness on the right at L4 and L5, which was mild and he had diminished range of motion. Straight leg raising was negative at 90 degrees bilaterally. The diagnosis was a lumbar herniated disc. No treatment recommendations were provided. An additional CT scan of the lumbar spine was obtained on 01/16/12. There were Schmorl's nodes

at L1, L2, L3, and L4, and there was an unfused anterior superior apophysis of the L5 vertebral body (limbus vertebrae). Mild annular disc bulges were present at all levels of the lumbar spine and there was no significant foraminal or spinal canal stenosis and the paraspinal soft tissues were unremarkable. On 02/08/12, the patient had worsening of his acute back pain two days prior with no injury recalled. He was on Naprelan and Skelaxin and noted his legs felt weak especially with climbing stairs. The recent CT scan was reviewed. Straight leg raising was negative bilaterally, but there was tenderness over the right paralumbar area that had increased since the last visit. Range of motion continued to be uncomfortable. The diagnoses were a bulging lumbar disc and a sprain of the lumbar region. The patient was continued on no work restrictions and an MRI of the lumbar spine was recommended. On 03/06/12, provided a Notification of Denial of Preauthorization for the requested lumbar MRI without contrast. On 04/10/12, TASB Risk Management noted they would not approve a repeat MRI, but would plain film x-rays of the lumbosacral spine, which were performed on 04/26/12. There were Schmorl's nodes particularly at L2 and an old un-united anterior superior annulus ossification centered at L5, which was of no acute significance. There was no evidence of subluxation during extension or flexion. The patient returned on 08/09/12. They were awaiting approval for the repeat MRI and he would be seen by the neurosurgeon following the MRI. His current medications were Nuvigil, Pravastatin, Flonase, and Naprelan. His examination was noted to be unchanged. He was continued on no work restrictions and asked to return in three months' time. On 11/15/12, provided another denial for the repeat lumbar MRI. reevaluated the patient on 11/28/12. He had to go to the emergency room for acute treatment about three to four days ago and he had worsening of his pain. He was unable to have medications filled that were prescribed in the emergency room and now he needed new ones. He had no loss of bladder tone or an ankle drop. Flonase, Lortab, Naprelan, Skelaxin, Ultracet, and Prednisone were prescribed at that time. Straight leg raising was negative bilaterally and neurological examination appeared normal. A repeat MRI was again recommended at that time. The patient returned on 02/12/13. He noted his back pain fluctuated in intensity, but remained unchanged. He received physical therapy previously and his back pain was unchanged and felt tight. They were still awaiting MRI approval. Flonase, Naprelan, Skelaxin, and Ultracet were continued, as well as Nuvigil and Pravastatin. There was right sided L4-L5 tenderness and reduced range of motion in the lumbar spine. Straight leg raising was negative bilaterally. Lower extremity examination was also within normal limits and neurological examination was normal. The diagnosis was a lumbar herniated disc. No work restrictions were continued and the MRI was again requested. On 04/09/13, TASB Risk Management Fund provided another denial of the MRI of the lumbar spine. The patient returned on 05/10/13. He complained of neck and back pain that had no improvement on his medications. It was noted he had been to the Office of Injured Employee and was advised to proceed with an MRI before 05/12/13. He needed a refill of his medications, which was provided at that time. His deep tendon reflexes were unchanged and straight leg raising was positive on the right in the sitting position at 45 degrees. Unrestricted duty was continued. On

05/13/13, provided another denial of the requested repeat lumbar MRI without contrast.

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

The use of an MRI is not an annular screening tool such as EKG or blood tests. The patient has had multiple evaluations of his spine, almost annually or semiannually since the lifting injury. He had an initial MRI of the spine performed on 02/02/07, which demonstrated degenerative changes and subsequent MRI in 2008 demonstrated essentially the same changes. Two subsequent CT scans showed progression of his degenerative changes, which is not unexpected given the passage of time. There are no abnormal neurological findings based on the documentation reviewed at this time. There is no evidence of instability. There is no objective physiological source of his ongoing pain. The ODG only approves/supports MRI evaluation when there has been an acute objective change related to the injury. The patient's symptoms are the same, out of proportion to the objective findings, and without a neurological element. It should be noted the patient's attending physician states that neurosurgery will not see the patient without a new MRI. There is no indication for a neurosurgical consultation; therefore that is not an appreciable reason to override the recommendations of the ODG. Therefore, the requested lumbar MRI without contrast is not appropriate or supported by the ODG and the previous adverse determinations should be upheld at this time.

**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)**