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Notice of Independent Review Decision

Date notice sent to all parties: 07/08/13 (AMENDED 07/15/13)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat 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.

Repeat lumbar MRI without contrast - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Employer's First Report of Injury or Illness dated xx/xx/xx
Reports dated 08/21/12, 08/28/12, 09/11/12, 09/25/12, 10/09/12, 10/23/12, 12/18/12, 01/18/13, 02/18/13, 02/27/13, 04/29/13, and 05/28/13

DWC-73 forms dated 08/21/12, 08/28/12, 09/11/12, 09/25/12, 10/09/12, 10/23/12, 11/06/12, 11/27/12, 12/18/12, 12/28/12, 01/18/13, 02/05/13, 02/18/13, 02/27/13, 03/26/13, 04/29/13, and 05/28/13
Lumbar x-rays dated 08/21/12
Physical therapy evaluation dated 08/30/12
Lumbar MRI dated 09/19/12
Cervical MRI dated 10/30/12 and interpreted
Report dated 11/02/12
Reports dated 12/28/12, 02/05/13, 02/07/13, 02/13/13, and 03/26/13
Urine drug screen collected on 12/28/12
Notices of Authorization dated 01/22/13 and 01/23/13
Designated Doctor Evaluation dated 04/02/13
DWC-69 form dated 04/02/13
Report dated 05/24/13
Script for orders dated 05/28/13
Preauthorization requests dated 05/29/13 and 06/15/13 (please note the reports stated the year 2012, but it is assumed to be a typographical error)
Notifications of Non-Authorization dated 05/31/13, 06/06/13, and 06/11/13
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

The Employer's First Report of Injury or Illness stated the patient was pulling and turning on xx/xx/xx and complained of back spasms in the lumbar spine. She was examined on 08/21/12. She had low back pain in the right paralumbar and right lower back area that radiated to the right buttock and right posterior thigh. She was five feet two inches tall and weighed 152 pounds. She had a normal gait and station, and her deep tendon reflexes and sensation were intact. The diagnoses were a back ache unspecified and a sprain of the lumbar region. Robaxin and Ultram were prescribed at that time. X-rays performed that day revealed a normal examination; however, the distal limb of the indwelling ventriculoperitoneal shunt catheter resided within the anterior abdominal cavity in a near midline location. A lumbar MRI was obtained on 09/19/12 and revealed disc degeneration at L4-L5 with broad based disc bulge. The disc bulge encroached upon the ventral margin of each L5 nerve root within the lateral recesses, greater on the left than the right. There was no critical spinal or neural foraminal narrowing identified. On 09/25/12, reexamined the patient. She noted no particular improvement except when she did "stretch therapy" at physical therapy. She continued with low back pain that radiated into the right posterior thigh. She also had leg pain and sciatica. She had back pain and also complained of radicular pain. She had tenderness of the lumbar spine over the right lumbar paraspinal muscles and the right SI joint. She had a normal gait and station. Right quadriceps strength was 4/5, as well as hamstring strength compared to the left at 5/5. Amitriptyline and Naprosyn were refilled at that time. On 10/09/12, Amitriptyline and Naprosyn were refilled. The patient was referred to by the patient's request. It was noted they were still awaiting epidural steroid

injection (ESI) approval On 12/18/12, the patient continued with radicular symptoms and had no ESI approval as of yet. Amitriptyline, Naprosyn, and Prilosec were prescribed and it was discussed that the patient could be referred for an ESI. then examined the patient on 12/28/12. The history was reviewed. It was noted she had a previous brain surgery of an unknown type in 1994. Her knee jerks were 1/4+ bilaterally and muscle strength was normal. Facet loading was positive in all planes, particularly in extension. There was mild diffuse tenderness over the lower lumbar segments. The straight leg raising was negative on the right at 70 degrees and on the left reproduced back, hip, buttock, and leg pain at 60 degrees. The impression was left lumbar radicular syndrome secondary to nerve root impingement at L4-L5. An ESI at L4-L5 on the left was recommended and Norco and Celebrex were prescribed. The ESI was performed on 02/07/13. On 02/13/13, the patient informed that she had minimal improvement in both her lower back pain and radicular symptoms. It was noted she was scheduled to see the next week. Her psychological screening that day showed mild depression. felt a surgical evaluation was indicated at that time. On 02/18/13, P.A., examined the patient for. She continued with low back pain that radiated. She was tender at the lumbar spine, but the remainder of the examination was essentially normal. It was noted the patient felt worse after the ESI than prior to. It was felt she needed to be referred. On 03/26/13, reexamined the patient. She had seen who advised her no surgery was indicated and she had received ESIs with no improvement. Celebrex was continued and she was advised to return to work as there was nothing else that could be done to her. The patient was asked to return in three months' time and she reported decent pain relief and was able to perform her activities of daily living (ADLs) on her current medication regimen. performed a Designated Doctor Evaluation on 04/02/13. The history and medical records were reviewed. Lumbar flexion was 45, 42, and 39 degrees. Extension was 11, 10, and 10 degrees. Left lateral flexion was 22, 18, and 21 degrees and right lateral flexion was 19, 16, and 15 degrees. Straight leg raising was positive bilaterally at 30 degrees. There was decreased normal sensation with hypoesthesia at L3, L4, and L5 dermatomes, both those dermatomes demonstrated +2 normal reflexes bilaterally. It was noted there was some slight atrophy of the calf of 1 cm., which could indicate possible neurological involvement. However, strength in the lumbar flexion, extension, and lateral flexion were 5/5 bilaterally. The diagnosis was thoracic or lumbosacral neuritis or radiculitis unspecified. It was felt the patient had not reached Maximum Medical Improvement (MMI) at that time and she was scheduled to undergo additional care including surgery and postsurgical rehabilitation. It was felt the patient would reach MMI on or near 10/02/13. On 04/29/13, reexamined the patient. She continued with left paralumbar and left leg sciatica that radiated to the left buttock and left posterior thigh. She was tender over the right SI joint and left SI joint, and her gait and station overall were normal. She was also tender in the lumbar spine. Amitriptyline, Prilosec, and Ultram were refilled and she had requested referral. The Maximum Medical Improvement (MMI) paperwork was reviewed. examined the patient at Back Institute on 05/24/13. She was helping bathe. She stated that holding the leg during a turn caused the immediate onset of pain. She had worked for three more days and was unable to tolerate the pain.

She was treated with two ESIs and physical therapy, but she could only tolerate eight sessions. The patient stood in a semi-flexed position and resisted any attempt to bring her to more neutral. She could barely hold a neutral stance posture and had increased pain with slight downward pressure on her shoulders. Palpation demonstrated withdrawal and exclamations of discomfort to fairly light superficial palpation transversely in the lumbosacral region, across the buttocks, and lateral hip. Distracted seated straight leg raising was negative bilaterally to 90 degrees. Motor examination showed Grade 5 strength in all motor groups tested with some breakaway, but not mechanical weakness in the hip flexors, abductors, and quadriceps hamstrings. Sensory examination showed no focal dermatomal deficit in the lower extremities. X-rays of the lumbar spine showed a mild right truncal list and five mobile lumbar vertebrae. There was some sinus lumbar height and lordosis on the lateral films and body morphology was normal. Disc heights were relatively well maintained except for L4-L5, which appeared decreased by 15-20%. noted the patient presented with subjective pain complaints, which were disproportionate to her objective findings and she had subjectively disabling pain, but on clinical examination really did not offer any objective findings of radiculopathy. She had very diffuse tenderness to fairly superficial palpation and guarded against range of motion. An EMG/NCV study and a new MRI of the lumbar spine were recommended. Tramadol, Omeprazole, Amitriptyline, Hydrocodone, and Celebrex were refilled at that time. reexamined the patient on 05/28/13. Naprosyn, Norco, and Ultram were refilled and it was noted she was pending an EMG/NCV study and MRI. On 05/29/13, the Back Institute requested a lumbar spine MRI without contrast at the request. On 05/31/13, provided a Notice of Non-authorization for the requested repeat MRI of the lumbar spine. On 06/05/13, again requested a lumbar MRI without contrast. On 06/06/13, also provided a Notice of Non-authorization for the requested bilateral lower extremity EMG/NCV study.

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

The patient had a lifting injury that occurred on xx/xx/xx. The patient underwent an MRI of the lumbar spine on 09/19/12. This showed mild disc desiccation and mild disc space narrowing with a broad based annular disc bulge slightly eccentric to the left. The patient recently was seen. He ordered an MRI on the basis that the prior MRI was not available and was over six months old. The patient was noted to have been disabled for 14 months and with subjective complaints disproportionate to the objective findings. noted that the clinical examination did not offer any objective findings of radiculopathy. The recommendation was made to review an MRI because she might have new pathology “such as a large central disc herniation”. A new MRI is neither reasonable nor necessary at this time. The ODG states “repeat MRI is not routinely recommended and should be reserved for significant change in symptoms and/or findings suggestive of significant pathology such as tumor, infection fracture, neural compression, or recurrent disc herniation”. The patient has none of these conditions. She has ongoing subjective pain complaints that have persisted long beyond the normal healing

timeframe for her minor injury. There is no rationale for repeating the study, as admits that there are no objective findings and he has significant suspicion of symptom magnification. In summary, the patient does not meet the ODG criteria for obtaining a repeat MRI without contrast and therefore, 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)