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Notice of Independent Review Decision

Date: June 5, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the lumbar spine

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

Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME:

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

X 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 (05/07/13, 05/15/13)
- Diagnostics (01/31/10 - 05/19/11)
- Office visits (02/09/10 - 04/15/13)
- Therapy (02/10/10 – 05/13/10)
- Reviews (05/07/10, 05/06/11)
- Utilization reviews (05/07/13, 05/15/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who on xx/xx/xx was lifting a box. As she leaned forward to put the box on a belt, she felt a painful pop in her lower back. She continued to work and her lower back continued to hurt.

2010: On xx/xx/xx, the patient was evaluated at the emergency room (ER). She underwent x-rays of the lumbar spine which showed anterior osteophyte at the superior endplate of L3 and disc space narrowing at L5-S1.

On February 9, 2010, evaluated the patient for right-sided low back pain radiating to right leg. The pain radiated to the buttock on the right and front of upper leg. There was no numbness. The patient had moderate pain and slow gait. Examination of the lumbar spine showed straight leg raise (SLR) to 90 degrees bilaterally, tenderness and decreased range of motion (ROM). Diagnosis was acute lumbar sprain. recommended physical therapy (PT) and light duty.

From February 10, 2010, through March 8, 2010, the patient underwent eight sessions of PT consisting of therapeutic exercises, neuromuscular re-education, moist hot pack and interferential current. Per therapy note dated February 10, 2010, the patient felt a painful pop in her low back on xx/xx/xx, as she bent forward to lower a can on the pallet. The pain was sharp and bad enough that it caused her to fall on her knees.

On March 1, 2010, recommended continuing medications, PT and light duty. The handwritten record is illegible.

On March 11, 2010, noted moderate ongoing low back pain. assessed lumbar strain and possible right lumbar radiculopathy. He discontinued tizanidine, prescribed Flexeril and tramadol, recommended PT and light duty and ordered magnetic resonance imaging (MRI) of the lumbar spine.

On March 25, 2010, noted moderate ongoing low back pain radiating to the right leg and foot. Her gait was very slow. Examination of the lumbar spine showed tenderness and decreased ROM. prescribed Motrin and recommended MRI of the lumbar spine.

On April 1, 2010, MRI of the lumbar spine showed relatively significant disc protrusion with a degree of extrusion at T11 to T12 and compression of the thecal sac and limited cord compression at that level. Clinical correlation was suggested. Findings were most marked centrally and extending into the neural foramina on the left side. At L2-L3, there was diffuse disc protrusion and limited compromise in the neural foramina bilaterally and possible degree of compromise at L3 nerve on the left. At L5-S1 there was mild disc protrusion of right paramedian area with no significant canal or foraminal compromise. There was minimal facet disease.

On April 8, 2010, noted that the patient was doing exercises at home which helped with pain. She was out of medications. She still had significant pain and slow gait. assessed lumbar sprain and T11-T12 disc herniation with thoracic radiculopathy, recommended continuing light duty and referred the patient On May 6, 2010, evaluated the patient for sharp, aching and constant low back pain rated as 7/10. It was noted that the patient was evaluated and treated with work

restrictions, medication and PT. However, the patient remained symptomatic and a lumbar MRI was performed. The patient remained on work restrictions. The pain was equally divided above and below the greater trochanters. The pain was 90% on the left lower extremity radiating into the great toe. History was positive for migraine headache and depression. Diagnosis was lumbar sprain, lumbago and sciatica. recommended medical management, PT and work restrictions.

On May 7, 2010, performed a peer review and rendered the following opinions: (1) No acute structural damage was sustained to either the thoracic spine or lumbar spine as related to the xx/xx/xx, work event. It was medically probable that the patient sustained a lumbar strain. Review of the lumbar MRI identified disease of life findings, including disc protrusion L2-L3 and L5-S1, with facet disease. The radiologist noted that the patient had a relatively significant disc protrusion at T11-T12 with degree of extrusion, compression of thecal sac and limited cord compression, with extension into neural foramina on the left side. In reviewing the available medical records, claimant had no left-sided symptoms, and only notes available were to the right. (2) Based on the mechanism of the work event, with no symptoms to correlate with the MRI findings and based on peer-reviewed literature, there was no medical probability that the MRI findings at T11-12 were causally related to a single load of lifting 10 pounds on xx/xx, 2010. (3) Most office visit notes were illegible, though none identified verifiable evidence of radiculopathy, either thoracic or lumbar. It was more probable than not that the extent of the xx/xx/xx, work event was a lumbar strain/sprain. (4) It was not medically probable that the patient had ongoing symptoms related to the xx/xx/xx, work event. She had undergone appropriate conservative treatment. Per the ODG, the effects of the lumbar strain should have resolved by this time, now 12 weeks status post work event. (5) Over-the-counter (OTC) Motrin would be reasonable per ODG criteria. No additional active treatment, injections, diagnostics, or referrals to a specialist would be reasonably required per ODG as related to a strain that occurred on xx/xx/xx.

On May 10, 2010, noted that the patient was seen who recommended more therapy. The patient continued to have moderate pain, tenderness and decreased ROM of the lumbar spine. assessed lumbar sprain and lumbar radiculopathy and prescribed Darvocet N.

On May 13, 2010, the patient underwent PT evaluation. She was recommended therapy three times a week for four weeks to include home exercise program (HEP), aquatic/pool, joint mobilization technique, manual therapy techniques, therapeutic exercises, neuromuscular re-education, manual ROM activities, aerobic conditioning, moist hot pack, interferential stimulation and mechanical traction.

On May 24, 2010, noted that the patient had moderate low back pain, tenderness and decreased ROM. He placed the patient off work and recommended follow-up.

On May 27, 2010, noted that the patient continued to have sharp, constant low back pain rated as 8/10. He noted that the patient was placed off work and the previously ordered PT was not performed. The patient was utilizing Ultracet and ibuprofen. recommended an MRI of the thoracic spine. It was noted that the lumbar MRI described a T11-T12 disc protrusion in the report but not in the impression.

On June 4, 2010, noted that the patient appeared to be in pain. She continued to have tenderness and decreased ROM of the lumbar spine. Diagnosis was chronic back pain, lumbar sprain versus lumbar radiculopathy. recommended electromyography/nerve conduction velocity (EMG/NCV) study of the lower extremities and an appointment. The patient was maintained off work.

Per utilization reviews dated June 22, 2010, and June 24, 2010, the request for EMG/NCV study and pain management consultation was denied.

On July 6, 2010, refilled tizanidine, tramadol/APAP and Motrin.

On July 21, 2010, the patient was noted to have significant low back pain, radiating left leg pain and left leg numbness. Diagnosis was lumbar sprain, T11-T12 disc herniation and lumbar/thoracic radiculopathy. prescribed Lortab.

On October 6, 2010, noted that the patient continued to have severe low back pain. The patient reported that she fell down x3. She had back pain and numbness in the left leg. Diagnosis was chronic back pain secondary to T11-T12 disc herniation. discontinued tizanidine and prescribed Skelaxin.

On October 27, 2010, the patient reported back pain radiating to the left leg. Her gait was slow. assessed chronic back pain and T11-T12 disc herniation. He refilled Skelaxin and Lortab.

2011: On February 1, 2011, noted that the patient continued to have chronic back pain secondary to disc herniation. He refilled the medication and recommended MRI of the lumbar spine.

On May 6, 2011, refilled Lortab and ibuprofen.

On May 6, 2011, performed a designated doctor examination (DDE) and opined that the patient had not reached MMI as she had not fully recovered. The patient was completely unable to perform any work duties. As a result of the accident, the patient reported to have experienced pain and related symptoms in her lumbar spine. The patient's disability was a direct result of the work-related injury, specifically for the dates in question being xx/xx/xx, through xx/xx/xx. The patient's extent of injury included the thoracic and lumbar spine area.

On May 19, 2011, MRI of the thoracic spine showed: (1) Narrowing of the disc space at multiple levels from T6-T7 through T9 and disc protrusion at these levels with some extension into the canal most marked at T8-T9 and T9-T10. (2) Compression of the thecal sac and mild compression of the spinal cord at T8-T9. (4) Disc protrusion at T11-T12 extending into the canal with possible limited compression of spinal cord at that level as well.

MRI of the lumbar spine showed: (1) Disc protrusion of approximately 4 mm near the midline at T11-T12 with minimally changed appearance. At L3-L4, there was generalized height loss, broad-based posterior bulge, and trace far left lateral protrusion less than 2 mm. (2) Contour irregularity to the posterior disc margin at L5-S1 reflected focal exaggeration of posterior bulge right paramedian without discrete protrusion. Spinal canal was widely patent throughout. (3) Moderate left foraminal narrowing at T11-T12, L1-L2, L2-L3 foramina were widely patent. There was mild right and moderate left foraminal narrowing at L3-L4. There was mild narrowing bilaterally at L4-L5, left slightly greater than right. There was mild right narrowing at L5-S1.

On June 2, 2011, noted that the patient continued to have moderate low back pain. assessed chronic back pain secondary to T11-T12 and L3-L4 disc herniations. He referred the patient a neurosurgeon.

2012: No records are available.

2013: On April 15, 2013, evaluated the patient for pain in the middle of back down to the tailbone rated as 10/10. Her pain was controlled by the pain medication. The patient complained of lack of sleep at night and she was able to sleep only for one to two hours due to pain. She was out of pain medication. She wanted a referral to an orthopedic surgeon. She also needed refills of her medications which were baclofen, ibuprofen, hydrocodone and acetaminophen. The patient had back pain radiating down to her left leg. Diagnosis was lumbar disc disease and pain. The patient was recommended MRI of the lumbar spine for the diagnosis of lumbar disc disease. The report is illegible.

Per utilization review dated May 7, 2013, the request for MRI of the lumbar spine was denied with the following rationale: *"In this case a MRI does not appear warranted. A review of the submitted progress report indicated that the patient described severe subjective complaints of back pain into her legs. The provider's examination on April 15, 2013, reported all the body systems examined as normal. A review of the submitted historical medical records revealed that the patient had previous MRIs to the lumbar spine on May 19, 2011, that reported previously described T11-T12 uncovertebral disc degeneration with central protrusion and with change; L3-L4 intervertebral disc degeneration that was slightly disc disproportioned and mildly worsened as compared to previous study; and mild-to-moderate, stable appearing degenerative disc disease (DDD) L5-S1. The previously referenced MRI was performed on April 10, 2010. The Official Disability Guidelines suggest that a repeat MRI is not routinely recommended,*

and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The submitted medical documents fail to provide any objective examination results to indicate a significant change in the patient's condition other than subjective complaints. Based on this discussion and a lack of evidence based guideline support, the prospective request for 1 MRI of the lumbar spine is recommended non-certified."

Per reconsideration review dated May 15, 2013, the request for MRI of the lumbar spine was denied with the following rationale: *"Based upon review of the submitted records, the prior non-certification appears to have been appropriate. Guidelines generally do not recommend repeat MRIs unless the patient meets the required indications or a significant change in symptoms has occurred. In addition, the most recent progress report did not provide any objective findings that would warrant the request of a repeat MRI. Therefore, the requested appeal for 1 MRI of the lumbar spine is recommended non-certified."*

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

Based upon review of the available records, the decision to uphold prior denials appears to be appropriate. ODG Guidelines do not recommend repeat MRIs unless certain criteria are met or a significant change in symptoms has occurred. Based on the medical notes there is little, if any, objective findings to support the need of a repeat MRI. In addition, the most recent progress report did not provide any objective findings that would warrant the request of a repeat MRI. Per ODG: "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)". Records do not support the need for a repeat MRI based on ODG.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES