

Matutech, Inc

881 Rock Street
New Braunfels, TX 78130
Phone: 800-929-9078
Fax: 800-570-9544

Notice of Independent Review Decision

Date: June 17, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of lumbar spine with/without contrast (72158)

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

Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

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

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is female who injured her back while lifting on xx/xx/xx (as per nurse's clinical summary). Per a report dated March 12, 2008, she twisted her back.

2006 – 2009: No records are available.

2010: On December 21, 2010, the patient underwent magnetic resonance imaging (MRI) of the lumbar spine. The clinical history was surgery in August 2007 and April 2010 and continued low back pain radiating to the right hip and right leg. The study showed the following findings: (1) At T12-L1, desiccation of disc with anterior spondylosis and 3-mm posterolateral disc bulge. No interval change as compared to previous examination. (2) At L1-L2, mild desiccation of disc with 2-mm posterolateral disc bulge. No interval change or encroachment of neural foramina. (3) At L2-L3, normal sagittal alignment and vertical disc height, normal hydration of the lumbar disc, normal facet joints and no significant central or foraminal stenosis. There was no evidence of epidural fibrosis. (4) At L3-L4, there was posterior laminectomy and moderate amount of scarring surrounding the thecal sac. There was no interval change as compared to the previous examination. Some left parathecal enhancing scar tissue with no interval change. (5) At L4-L5, there was right laminectomy which appeared to be a new finding as compared to previous examination. Some scar tissue in the right parathecal region. There was mild facet hypertrophic change with hypertrophic ligaments. (6) At L5-S1, normal sagittal alignment and vertical disc height. There was normal hydration of the lumbar disc, normal facet joints and no significant central or foraminal stenosis and no evidence of epidural fibrosis. Previously seen cyst in the right ovary measuring 2.3 cm was again visualized and showed no interval changes.

2011: On July 19, 2011, evaluated the patient for low back and right leg pain. The patient reported that she was doing very well following her surgery. She had completed postoperative physical therapy (PT) with improvement in her low back pain. She had returned to work and was working full time while doing her PT. Unfortunately, she had an aggravation of her leg pain and suffered with what appeared to be a right L5 radicular pain. She had some relief with Neurontin but it caused weight gain. She was utilizing Lortab but wanted to reduce the dose. Her selective nerve root block (SNRB) request was denied. She reported that her symptoms began on xx/xx/xx, when she lifted something and twisted her back. Her prior surgery included lumbar decompression in January 2007 with. The patient reported that she was doing well until she re-injured her back at work in xx/xx. She then had surgery on April 20, 2010,. Her treatment included opioid medication which relieved the pain and PT which helped the pain. Her back pain was located on the right side and was rated as 5-6/10. The pain was moderate, improving, sharp, intermittent and achy in nature. She also had muscle spasms and burning. Her pain radiated to the right foot and it was severe (>8), burning and intermittent in nature. History was positive for chronic back pain, depression, high blood pressure, irregular heartbeat, migraine and a history of peptic ulcer disease. The patient was utilizing lisinopril, Wellbutrin, Flexeril, Lortab, Neurontin, multivitamin/minerals, fish oil and baby aspirin. Review of systems (ROS) was positive for numbness and tingling. Neurological examination showed paresthesias into the right dorsal foot, decreased pinprick sensation in the right L5 dermatome and decreased two-point discrimination in the right L5 dermatome. The right extensor hallucis longus (EHL) strength was 4/5. Sitting straight leg raise (SLR) was positive on the right and negative on the left.

Diagnosis was right lumbar radiculopathy. The patient had radicular-type pain in the right leg. recommended electrodiagnostic study to further localize the possible level of neural impingement and based on the results, deciding to proceed with an SNRB. The patient was interested in tapering off the hydrocodone. prescribed hydrocodone 5 mg tablets to taper down with. The patient was to continue home exercise program (HEP).

On August 18, 2011, noted that the patient continued to have low back pain radiating down into the right leg. She complained of numbness and tingling in her right foot and toes. Her symptoms increased with sitting or standing. She reported that Cymbalta was working great, but she was unable to sleep at night. She had lost 9 pounds off Neurontin. She noted that she did have initial side effects including nausea which had improved and diaphoresis which had not. ROS was positive for sleep problems, weakness, numbness and tingling. performed an electromyography/nerve conduction velocity (EMG/NCV) study which showed electrodiagnostic evidence of mild-to-moderate, subacute, right L5-S1 radiculopathy with signs of active denervation on needle exam. It was noted that the patient had made significant improvement in terms of pain while on the Cymbalta. She did have some residual burning pain in her L5 and S1 distribution. recommended proceeding with an SNRB to further reduce her radiculopathy. The patient had weaned off opioid medications and had continued to work full-time. added Elavil at night for control of neuropathic pain and improved sleep and recommended continuing Cymbalta, Flexeril and baby aspirin.

On November 7, 2011, Dr. Nash performed SNRB at right L5 and S1.

2012: On January 26, 2012, noted that the patient was doing very well after the injection with about 90% relief until one week ago when she noticed increased pain. The patient reported that she was doing so well that she did not have to take the medications for a few days. She was beginning to have a burning sensation down the right leg. She wanted to repeat the L5-S1 right SNRB. Her pain was mild-to-moderate with medications and was rated as 3-4/10. Examination of the lumbar spine showed loss of lordosis and spinal tenderness at L5-S1. assessed right lumbar radiculopathy and chronic low back pain and discussed various treatment alternatives including conservative versus more invasive treatment including epidural steroid injection (ESI). He recommended continuing Cymbalta, Elavil and Lortab. He also recommended a repeat L5-S1 SNRB.

On February 13, 2012, performed an SNRB at right L5 and S1.

On August 7, 2012, evaluated the patient for lumbar pain. The patient did very well following the SNRB in February. She complained of low back pain which was severe, progressive, sharp, dull, achy and burning in nature located in the central, left side and right side, radiating to the bilateral buttocks and legs. The patient had not taken pain medication since May. She had noted recurrence of right leg symptoms over the past three to four weeks. Her treatment had included opioid medication which relieved the pain, ESI which relieved the pain and muscle

relaxers which revealed muscle spasms. Her range of motion (ROM) was stiff and her pain radiated to the bilateral buttocks, hips, thighs, knees and feet. She also had weakness and spasms/cramps. ROS was positive for sleep problems, numbness, tingling, loss of balance and depression. Sitting SLR was positive on the right. recommended repeat right L5 SNRB, as the patient had experienced greater than 50% reduction in the leg pain following the prior procedure. He also recommended medication refill and urine drug screen.

On September 10, 2012, performed bilateral L5 SNRB.

2013: On January 15, 2013, evaluated the patient for increased low back pain. Her pain was severe and was located central and right-sided. Her pain level was 6-7/10 with medications. The pain radiated to the left foot. It was moderate-to-severe and was rated as 6-7/10, not progressing, sharp, achy and burning. It was also intermittent, worse at night, present during the day and present at night. Her symptoms increased with activities, standing and walking. The symptoms decreased with lying down. She also reported leg falling asleep. The left hip was painful to the greater trochanter. Her pain radiated to the right hip, knee and foot. It was intermittent and present during the day and at night. Neurological examination showed trace weakness in the right anterior tibial, decreased pinprick sensation and two-point discrimination in the right L5 dermatome. There was spinal tenderness at L4-L5 and positive sitting SLR bilaterally. recommended continuing Lortab, Flexeril, Cymbalta and amitriptyline and obtaining EMG/NCV study of the left lower extremity given the patient's worsening leg symptoms and failure of last SNRB to help her symptoms.

On February 28, 2013, noted that the patient continued to have bilateral leg pain, numbness and tingling. The patient reported that her legs were sensitive to touch and she was having a burning sensation in both legs. She had previously had more pain on the right side but recently she had increased pain on the left side, the distribution was along the posterolateral margin along with associated burning and tingling sensation. The EMG/NCV study showed electrodiagnostic evidence of left L5-S1 radiculopathy with signs of active denervation on needle exam and an acute-on-chronic right L5-S1 radiculopathy with evidence of ongoing denervation. recommended trial of additional 30 mg Cymbalta with current 60 mg dose to see if it provided improvement in neuropathic pain. noted that urine drug screen was positive for alcohol. The patient was to continue Flexeril and baby aspirin.

On March 20, 2013, ordered MRI of the lumbar spine with and without contrast.

Per utilization review dated March 25, 2013, the request for MRI of the lumbar spine with and without contrast (72158) was denied, with the following rationale: *"This is a female who hurt her back in xxxx. History is significant for lumbar decompression surgeries in 2007 and 2012. A request for lumbar spine MRI with and without contrast is made. On August 7, 2012, the patient reported progressing right-sided radicular back pain. There was no documentation of severe or progressive neurologic deficits. On January 15, 2013, the patient*

complained of increased low back pain. Still, there was no evidence of severe or progression of neurologic deficits. Electrodiagnostic studies were recommended. An EMG/NCV was performed on February 28, 2013, revealing bilateral L5-S1 radiculopathy. She returned on February 28, 2013, reporting an increase in left-sided radicular pain. There was no physical examination documented. This patient has undergone series of lumbar spine MRIs, the latest on December 21, 2010. The referenced treatment guidelines indicate that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Although this patient has had a chronic radicular back pain and has undergone lumbar surgeries, the recent records do not reflect significant change in clinical condition evidenced by progressive or severe neurologic deficits. A clear indication for performing an MRI with contrast was not discussed. As there is no evidence for significant clinical progression and without a reason for contrast study, the requested MRI study has not been substantiated."

On April 18, 2013, recommended proceeding with an MRI of the lumbar spine to evaluate the possible source of nerve root impingement.

On April 25, 2013, evaluated the patient for low back pain. The patient had increased pain the last three weeks and had not been able to work due to pain. She had to go to the hospital and had even been admitted for pain. She reported the increase in Cymbalta had helped slightly. She had to get a walker to help her ambulate. Her pain level was more than 8 and it was described as severe, sharp, dull, achy and burning in nature. The pain was intermittent and located centrally. She reported that her symptoms increased with activities, sitting, standing, getting up from a chair, bending forward, bending backwards, walking, twisting, climbing stairs, changing positions and laying down. Other symptoms included muscle spasms, numbness and tingling. Her ROM was stiff. The pain radiated to the left foot and it was severe, more than 8, sharp, dull, achy, burning and constant in nature which increased with activities, sitting, standing from a sitting position, walking, bending backwards and forwards. She also had left foot weakness. ROS was positive for fatigue, sleep problems, blurry vision, numbness, tingling, loss of balance, anxiety and depression. Examination showed trace weakness in the right anterior tibial, decreased pinprick sensation and two-point discrimination in the right L5 dermatome. There was loss of lumbosacral lordosis and spinal tenderness at L5-S1. She had positive sitting SLR and contralateral SLR in back bilaterally. She had 4/5 strength with full sensation to light touch in the superficial peroneal, deep peroneal and posterior tibial nerve distribution and 2+ dorsalis pedis pulse. It was noted that the patient had demonstrated good analgesia with no adverse side effects and had demonstrated improved functional capacity. She was currently stable and was recommended to continue Lortab, Flexeril, Cymbalta and amitriptyline. recommended activities as tolerated and ordered urine drug screen. He resubmitted the request for a lumbar spine MRI and recommended continuing HEP.

Per reconsideration review, the request for MRI lumbar spine with and without contrast was denied. The rationale is not available.

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

An MRI is within guidelines if the symptoms have changed, and they can be related to the original injury. The patient now has signs and symptoms consistent with complex regional pain syndrome, which is related to the original injury, but is a diagnosis which can only be excluded if the MRI demonstrates pathology (either changed, or unchanged) consistent with such diagnosis. Thus, an MRI with and without gadolinium is medically necessary.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES