

Notice of Independent Review Decision

February 28, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI lumbar spine

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

Board Certified Physical Medicine and Rehabilitation Physician

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.

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Office visits (12/19/12 – 02/08/13)
- Utilization reviews (01/08/13 – 01/30/13)

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- Office visits (01/26/11 – 04/18/11)
- Diagnostics (02/10/11)
- Utilization reviews (02/09/11 – 03/23/11)

- Surgery (04/29/11)

D.C.

- Office visits (01/19/06 – 12/19/12)
- Therapy notes (04/07/05 – 12/07/11)
- Diagnostics (05/11/01 – 02/02/11)

TDI

- Utilization reviews (01/08/13 – 01/30/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was decorating for Halloween on xx/xx/xx, and fell a couple of feet off a ladder landing on her feet with most of the impact to the left leg.

2001 – 2005: On May 11, 2001, M.D., performed electromyography (EMG) study of the upper extremities. He noted that the patient had suffered a trauma to her neck and arms and had difficulties with severe pain in the cervical area and some ill-defined paresthesia in both arms, left worse than right. Dr. opined that the study failed to demonstrate significant electrical abnormalities.

On October 18, 2001, magnetic resonance imaging (MRI) of the lumbar spine revealed modest osteophytosis at L1-L2 and minimal osteophytosis at the other levels. All of the lumbar discs were desiccated with anterior narrowing of the L1-L2 disc and posterior narrowing of the L5-S1 disc. There was slight posterior extension of the disc signal at each of these levels. There was a diffuse disc bulge at L5-S1; the spinal canal remained widely patent but in combination with facet hypertrophic changes at the level, the foramina were narrowed and there was exiting nerve root abutment on the left and superior displacement on the right.

On November 9, 2001, M.D., evaluated the patient and noted the following treatment history: *Following the injury, the patient went to Dr.. A few months later the patient changed treating doctors to Dr. who concentrated on the left knee. Someone else was attending to the neck and again all of this was unclear as the patient exhibited dulled cerebration. Eventually, the patient changed treating doctors again to Dr. who ordered EDX testing to rule out lumbar radiculopathy.* The patient complained of lower back pain described as sharp and constant, and left knee pain. History was positive for high blood pressure and diabetes. Examination revealed ambulation with a cane and assistance with lying on her stomach and back. The patient was endomorphic and very obese. She was unable to perform heel/toe and tandem gait. Dr. noted electrodiagnostic evidence of a predominantly sensory peripheral neuropathy and a probable chronic lumbar radiculopathy, more evident on the right but probably involving at least the S1 root bilaterally and the L5 root on the right. She opined that the findings appeared to correlate to the MRI findings from October 18, 2001. However, it was unclear how well these findings correlate to the mechanism of injury or clinical exam findings.

No records are available from 2002 through 2003.

On December 15, 2004, D.C., evaluated the patient for discomfort in the neck, headaches, constant burning sensation in the lower back and tingling and numbness in the left arm and both legs. Examination revealed decreased pinprick and light touch sensation at S1 on the right; positive cervical distraction, positive maximum foraminal compression testing bilaterally and positive shoulder depression bilaterally. Supine straight leg raising (SLR) was not performed due to significant pain in the recumbent position. There was positive sitting and standing Kemp's tests bilaterally for increase in low back pain. The Valsalva's test was positive for an increase in low back pain indicating a probable disc lesion. There was medial and lateral joint line tenderness with a positive Apley's and grating on medial loading and flexion-extension, positive McMurray's on the right. Varus and valgus stress tests were positive on the right. Soft tissue palpation elicited pain and revealed severe myofascial trigger points and myospasms in the cervical, thoracic and lumbar paraspinals, gluteal and upper trapezius musculature. She had increased cervical lordosis and pelvic elevation on the left with a lateral shift in weightbearing to the right. She had severe antalgic gait with decreased stride and step and a forward leaning posture. The patient ambulated with the use of a cane. There was decreased range of motion (ROM) of the cervical spine, lumbar spine and left knee. Dr. reviewed MRI of the cervical spine dated April 23, 2001, that revealed discal pathology at C4-C5, C5-C6 and C6-C7 with extradural compression at C4-C5 and C5-C6 associated with combined discal pathology and herniation with stenosis. Dr. felt that the patient's complaints were consistent with a chronic injury to the cervical, lumbar spine and left knee. He noted that the patient had received 42% impairment rating (IR) by Dr. Earle on June 25, 2002. He diagnosed displacement of lumbar intervertebral disc (IVD), cervical IVD with myelopathy, cervical radiculitis, internal derangement of the knee, myalgia/myositis and radiculitis. He ordered MRI of the lumbar spine and left knee.

From January through February 2005, the patient attended therapy consisting of aquatic therapy, electrical muscle stimulation (EMS), myofascial release, joint mobilization and ultrasound.

On January 4, 2005, MRI of the left knee revealed partial medial meniscectomy with a recurrent tear through the residual posterior horn of the medial meniscus communicating with the femoral surface, a horizontal cleavage tear through the anterior horn of the lateral meniscus and a moderate joint effusion. There was moderate degenerative joint disease (DJD) with joint space narrowing and prominent osteophytes of the femorotibial and patellofemoral joints.

On January 4, 2005, MRI of the lumbar spine revealed multiple small Tarlov or arachnoid cysts involving the inferior aspect of the thecal sac and moderate facet joint arthrosis at L4-L5 with mild bilateral foraminal narrowing. There was

moderate facet joint arthrosis at L5-S1 with mild narrowing of the left neural foramen.

On February 3, 2005, the patient underwent a physical performance evaluation (PPE). The evaluator opined that she was not at her physical demand capacity (PDC) and she was not a surgical candidate. The patient was recommended 30 sessions of chronic pain management program (CPMP).

On March 9, 2005, Dr. noted that the patient was in chronic pain and was unable to work due to her significant decrease in positional tolerance. He referred the patient for pain medications and recommended six individual counseling sessions.

From April 7, 2005, through December 6, 2005, the patient had regular follow-ups at Spine and Rehab.

On April 25, 2005, M.D., evaluated the patient for constant burning pain in the neck, low back and left knee. The patient had active and passive therapy with some improvement to the lumbar spine. She has had injections, therapy, surgery and medications. Examination revealed pain and spasm of the paraspinal musculature and around the left knee. There was severe antalgic gait with decreased stride and step and a forward leaning posture. Examination of the left knee revealed moderate left VMO atrophy. Examination of the cervical spine revealed centralized tenderness at C4-C8 with moderate-to-severe myospasms and decreased motion. Examination of the lumbar spine revealed centralized tenderness at L4-S1 with moderate spasms and decreased motion. Dr. diagnosed displacement of lumbar IVD, cervical IVD, cervical radiculitis, internal derangement of knee, myalgia/myositis, radiculitis and chronic pain syndrome (CPS). He prescribed Flexeril and Ultram and recommended six sessions of individual counseling.

On May 16, 2005, Dr. noted constant low back pain with numbness in both legs. He opined that the patient would be unable to work until treatment was approved/authorized by the carrier.

On June 6, 2005, Dr. refilled Flexeril and Ultram and recommended continuing CPMP.

On September 12, 2005, and October 24, 2005, Dr. prescribed Soma and referred the patient for an orthopedic consultation.

On October 26, 2005, Dr. referred the patient to Dr. for evaluation and treatment.

2006 – 2010: From January 9, 2006, through December 4, 2006, the patient had multiple follow-ups at Spine and Rehab.

On January 9, 2006, D.C., evaluated the patient for constant low back pain with numbness in both legs. She further noted constant left knee pain. She felt upset

and frustrated because she could not perform the activities that she used to. Dr. recommended active and passive therapy.

On January 30, 2006, Dr. noted some improvement to the lumbar spine. Examination revealed pain and spasm of the paraspinal musculature and around the left knee, severe antalgic gait with decreased stride and step and a forward leaning posture. Dr. prescribed Soma and recommended orthopedic consultation.

On February 16, 2006, Dr. noted an acute exacerbation to the lumbar spine. Dr. had recommended surgery and opined that PT was never indicated for any patient under any circumstances.

On March 14, 2006, Dr. refilled Soma. He noted that Dr. had performed a peer review and indicated that surgery was necessary and PT was never indicated.

From January 19, 2007, through May 8, 2007, the patient attended therapy.

On January 19, 2007, Dr. noted that the patient was referred to Dr. for an orthopedic consultation which was denied.

On February 20, 2007, Dr. opined that the patient's condition was deteriorating due to the continuation of unnecessary denials and recommended evaluation by an orthopedic surgeon.

On February 22, 2007, Dr. prescribed tramadol/APAP, recommended continuing home treatment and evaluation by Dr..

On March 20, 2007, Dr. noted that the patient was evaluated by Dr. who had recommended lumbar injections.

On May 8, 2007, Dr. noted that the patient had a facet injection to the lumbar spine on April 19, 2007. She was able to work part time with restrictions.

On June 13, 2007, the patient was evaluated at Spine and Rehab. The evaluator noted that the patient had MRI of the lumbar spine that revealed L4-L5 and L5-S1 facet joint arthrosis with bilateral foraminal narrowing and a 3-mm disc bulge at L5-S1 with narrowing. The MRI of the left knee had revealed a recurrent tear through the posterior horn, a tear at the anterior horn and moderate joint effusion.

From June 18, 2007, through December 6, 2007, the patient had regular follow-ups at Spine and Rehab and attended therapy.

On July 31, 2007, Dr. refilled tramadol and recommended continuing therapy.

On October 30, 2007, Dr. noted that the patient had two injections to her knees with a third scheduled. He recommended therapy.

On January 9, 2008, through December 18, 2008, the patient had regular follow-ups at Spine and Rehab. It was noted that the patient had injections of Depo-Medrol and Kenalog to her knees.

On January 22, 2008, Dr. refilled Neurontin. He noted that the patient had psychotropic medication and individual counseling. He opined that a 20 session CPMP was medically necessary.

On March 11, 2008, Dr. noted that the patient had a partial meniscectomy on the left knee by Dr. on May 24, 2004. She was using a walker and was not attending therapy. Dr. refilled tramadol/APAP and recommended therapy.

On August 12, 2008, Dr. noted neck pain radiating to right arm. The patient was dropping objects from her right hand. Dr. had issued new knee braces. He prescribed Lexapro, Lidoderm patches, Citracal caplets and Soma. He recommended continuing therapy.

From September 16, 2008, through December 23, 2008, Dr. refilled medications on a regular basis.

From January 9, 2009, through December 19, 2009, the patient had follow-ups at Spine and Rehab and was treated with injections of Kenalog and Depo-Medrol to the knees.

From May 26, 2009, through December 8, 2009, the patient received refills of Lexapro, Citracal, Vicodin and Lidoderm patches.

On November 2, 2009, Dr. referred the patient to Dr. for evaluation of the knees.

On March 9, 2010, and December 7, 2010, Dr. refilled Lexapro, Lidoderm, Citracal and Vicodin.

2011 – 2012: On January 26, 2011, M.D., an orthopedic surgeon, evaluated the patient for bilateral knee pain, left significantly greater than right. She had difficulty with startup, stairs, night pain, weakness and giving way. She had been treated with injections and therapy. Examination of the left knee revealed positive bilateral joint line pain, mild effusion and positive quad weakness. Examination of the right knee revealed moderate amount of joint line pain bilaterally and quadriceps weakness. Dr. ordered x-rays and MRI of the bilateral knees.

On February 2, 2011, D.C., obtained electromyography/nerve conduction velocity (EMG/NCV) and diagnosed mildly active lumbosacral radiculopathy that affected the left S1 nerve root and findings suggestive of an acute to sub-acute process. There was evidence strongly suggestive of right S1 root pathology.

On February 10, 2011, x-rays of the right knee revealed tricompartmental osteoarthritic changes, most prominent in the medial compartment. X-rays of the

left knee revealed tricompartmental osteoarthritic changes most prominent in the medial compartments, and mild genu varus.

MRI of the left knee revealed medial meniscal tear, grade I/II sprain of the medial collateral ligament (MCL) with grade II/III sprain of the medial patellofemoral retinaculum with adjacent extracapsular synovial/ganglion cyst. There was interstitial degeneration versus chronic sprain of the anterior cruciate ligament (ACL). There was tricompartment osteoarthritis with high-grade medial femorotibial and patellofemoral compartment cartilage loss and small Baker's cyst.

On April 19, 2011, Dr. refilled Lexapro, Lidoderm, Vicodin and Citracel tabs. He recommended 12 sessions of postoperative aquatic PT.

On April 29, 2011, Dr. performed left knee arthroscopy. Postoperatively, he noted no complaints and pain only elicited with protracted walking. He recommended exercises.

On June 7, 2011, Dr. noted pain in the lower back radiating down to the right and left ankles as well as pain in the right knee. Dr. refilled medications.

From June 13, 2011, through December 7, 2011, the patient attended therapy at Spine and Rehab.

On September 13, 2011, D.C., recommended therapy.

On January 11, 2012, and February 7, 2012, the patient was evaluated at Spine and Rehab. The evaluator recommended functional capacity evaluation (FCE).

No records are available from March 2012 through November 2012.

On December 19, 2012 D.C., evaluated the patient for constant neck, mid lower back and bilateral knee pain. The patient reported that she was severely depressed as she was unable to complete simple activities of daily living. Review of systems (ROS) was positive for severe depression and antalgic gait. Sensation to pinprick and light touch were decreased over the left lower extremity. Examination revealed positive cervical distraction for increase in posterior cervical myalgia, positive maximum foraminal compression testing and positive shoulder depression. Orthopedic exams designed to stress the sciatic nerve elicited symptomatology associated with myalgia, Kemp's reproduced the patient's symptomatology which indicated disruption of the lumbar joints and O'Donoghue's revealed muscular strains and ligamentous sprains. There was atrophy of the right thigh. There was decreased ROM of the cervical and lumbar spine. Dr. diagnosed lumbar disc displacement, cervical disc protrusion, internal derangement of the knee, lumbar sprain/strain, cervical sprain/strain and knee sprain/strain. He ordered MRI of the lumbar spine.

2013: Per utilization review dated January 8, 2013, the request for repeat lumbar MRI was denied. The evaluator noted a required medical evaluation (RME) had been performed by M.D., on December 29, 2008. Dr. had opined as follows: (1) The diagnosis was cervicalgia without radiculopathy, lumbago without radiculopathy and degenerative arthritis of both knees. She had degenerative arthritis of both knees which was due to her weight. (2) The care was not reasonable and necessary. She had been in a pre-maintenance program. No further injections were reasonable. The patient needed to work on weight reduction and home exercises and see a doctor for medication no more than twice a year. She does not need any further chiropractic care and no further diagnostic test was appropriate. The patient was seeing the chiropractor once a month and her doctor once a month which was totally unnecessary. The patient needed to see an M.D. no more than twice a year. The patient would benefit from an active home exercise program (HEP). PT was not appropriate. (3) The patient was not a surgical candidate for any procedure except possibly for total knee replacements which would be done through Medicare and not through Workers Comp. She was not a surgical candidate for either the neck or the back. The request for MRI of the lumbar spine was denied with the following rationale:

“This lady had a work incident In xxxx . She has had extensive evaluation already. The rationale for repeat MRI of the lumbar spine appears inconsistent as the reflexes are decreased on the left but then motor strength is listed as bilaterally decreased proximally. Moreover, the calf circumference is symmetrical. There have been prior imaging studies completed. The RME done by Dr. did not find any further care needed as related to the work incident except maintenance care. Thus the request is not validated as a medical necessity for the work incident of xxxx.”

In letter of medical necessity dated January 24, 2013, Dr. opined that the request for lumbar MRI was denied solely based on a 2008 RME opinion and had failed to take into account the clinically significant unilateral loss of reflexes with significant unilateral muscular atrophy. It was in all reasonable medical probability to presume that the patient’s current clinical findings of unilateral loss of reflexes and muscular atrophy were secondary to progressive neurological deficit. He appealed for the lumbar MRI.

Per reconsideration review dated January 30, 2013, appeal for MRI of the lumbar spine was denied with the following rationale: *“The patient is a female who sustained an injury on xx/xx/xx, when she fell. The patient was followed for ongoing complaints of neck and mid and low back pain as well as bilateral knee pain. Clinical evaluation onxx/xx , reported decreased sensation in the left lower extremity with no unilateral reflex loss. Weakness was present at the hip and leg flexors and extensors, however. This was bilateral. The weakness appeared to be due to pain and guarding. No radicular symptoms were elicited. Some thigh atrophy was noted on the right versus the left. There was loss of range of motion in the lumbar spine. The patient was recommended for updated MRI studies of the lumbar spine. The request for a repeat MRI of the lumbar spine would not be recommended as medically necessary. Although the patient is noted to have*

thigh atrophy in the right lower extremity as compared to the left, no prior imaging studies were provided for review to determine if the prior studies identified pathology that would reasonably correlate with objective findings. There is no indication from the clinical notes that the objective findings are new or progressively severe. Without prior imaging studies to determine whether there are any correlative findings that have already been identified, and without any evidence of severe progressive new neurological deficits in the lower extremities, medical necessity would not be established at this time.”

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

Based on the medical records a repeat MRI does not meet ODG criteria, “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”. Although there is an exam reporting right thigh atrophy an earlier exam reported left thigh atrophy. In addition, DTRs were asymmetric per Dr. report patella was 2/5 right and 1/5 left and ankles were 2/5 right and 1/5 left the opposite the reported atrophy, which is clearly inconsistent and weakness was bilateral.

In conclusion, there is no evidence to support the need for a repeat MRI.

IRO REVIEWER REPORT TEMPLATE – WC

**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