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Notice of Independent Review Decision

Date notice sent to all parties: 03/11/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat lumbar MRI

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 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

X-rays of the lumbar spine were obtained on 01/23/10 and interpreted by, M.D. There was no acute fracture or subluxation identified. There was degenerative disc space narrowing at L3-L4 and L4-L5. , D.C. examined the patient on 01/07/11. The patient stated he was a paramedic and was transferring a patient to his right onto a bench sheet in the back of the ambulance when he injured his back. When it happened, he felt like something gave way in his back and he rated his pain at 7/10. He noted when he stood his legs seemed to get weak and on one occasion he had numbness in the right foot. Otherwise, he also experienced bilateral lateral thigh pain. He also had a sensation where he had to go to the restroom frequently for a bowel movement, but did not necessarily have to do that. He did report an injury to his low back a year and a half prior that required some physical therapy. He was noted to be non-diabetic. He was able to ambulate on his own, but did so slowly and with a limp. He reported the limp would actually vary from one leg to the other as the low back pain did also vary from one side to the other. He had equal perception of both pinwheel and vibration of the lower extremities. His reflexes were 1+ at the patella and 2+ and sluggish at the Achilles. He had good strength in the lower extremities. He had a positive left seated straight leg raising at 45-50 degrees.

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He was tender to palpation in the lumbar spine at L5-S1 all the way to L3. A lumbosacral sprain/strain and spasms were the assessment and the possibility of spondylolisthesis was also noted. X-rays of the lumbar spine dated 01/12/11 were noted to be normal. , M.D. interpreted an MRI of the lumbar spine on 01/12/11. There was very minimal degenerative disc disease along the lumbosacral spine with mild facet arthropathy, primarily involving the right L4-L5 facet with a small facet joint effusion and mild osteophytic spurring, but no significant reactive bone marrow edema seen. On 04/06/11, Dr. noted the patient had received one epidural steroid injection (ESI) a few weeks back and had very good relief for about two weeks. After two weeks, his pain had returned. He also reported that early on in the injury he did have some episodes of his left foot going completely numb, but has not had anything to that degree since. The patellar reflexes were +1 bilaterally and the Achilles' reflexes were 2+ and brisk. He had decreased perception of vibration in the left great toe when compared to the right. An EMG/NCV study was recommended. , D.O. performed a bilateral L4-L5 and L5-S1 medial branch block on 06/14/11. Dr. reexamined the patient on 07/29/11 and he was still having some back and lower limb symptoms. Neurontin seemed to help the lower limb symptoms. He had no progressive weakness or bowel or bladder changes. Straight leg raising induced buttock pain on the right at 60 degrees, which was negative on the left. He had normal strength in the lower limbs and no atrophy. Flexeril was prescribed at that time. Paul Geibel, M.D. examined the patient on 08/19/11. Here it was noted the patient he was lifting was 205 pounds. He had an EMG/NCV study that was indicative of radiculopathy. He smoked 3/4 of a pack per day and consumed alcohol occasionally. He was six feet two inches tall and weighed 230 pounds and walked with a non-antalgic gait. He had left posterior iliac spine and left SI notch tenderness. Forward flexion was 80 degrees and left lengths were equal. Neurological examination revealed 5+/5+ motor strength and decreased sensation at L5 on the left. The impression was lumbar radiculopathy; rule out L5-S1 root compression. A lumbar CT myelopathy was recommended at that time. James Bales, M.D., an orthopedic surgeon, performed a Designated Doctor Evaluation on 06/20/12. His current medications were Morphine, Hydrocodone, Gabapentin, Cyclobenzaprine, and Omeprazole. Lumbar range of motion was noted to be normal and muscle strength was 5/5 bilaterally. The diagnoses were a lumbar spine L5 pars interval displacement and disc bulges at L4-L5 and L5-S1. Dr. felt the patient had not reached Maximum Medical Improvement (MMI) and this was due to his new found information of elongation of the pars when comparing the pre and post injury MRIs. Dr. noted the

pars fractures were present on both the MRI prior to the injury and after the injury so it stood to reason that the pars fractures themselves were not caused by the injury. However, he agreed with Dr. that elongation of the L5 pars found on the second study was consistent with interval displacement stood to reasonable medical probability of being caused by and related to the original injury. Dr. felt the facet arthropathy was a disease of life and not related to the original injury. He also felt it made reasonable medical sense that the disc bulges at L4-L5 and L5-S1 were secondary to the elongations suggesting interval displacement of L5. X-rays and a lumbar MRI comparison were performed on 03/27/12 and interpreted by, M.D. The x-rays of the lumbar spine were compared to ones performed on 01/23/10. Both studies showed L4 and L5 pars fractures and apparent new 3 mm. anterior displacement of the L5 pars fractures on the second study. The MRI of the lumbar spine was compared to one performed on 02/07/10, which both studies showed L4 and L5 pars fractures. The remainder of this impression was not provided for review. A CT myelogram of the lumbar spine was obtained on 04/26/12 and interpreted by Dr. There was a central disc protrusion at L5-S1 with abutment of the thecal sac, but no compression of either the L5 or S1 nerve root. On 08/03/12, Dr. reexamined the patient. Lumbar flexion was 70 degrees and extension was less than 5 degrees and quite painful. Dr. noted that although prior EMGs were normal, his clinical symptoms supported that of lower extremity radiculopathy, certainly on the left, but also on the right. , M.D. performed a Required Medical Evaluation (RME) on 10/09/12. There was no spinous tenderness to palpation of the lumbar spine. Lumbar flexion was 90 degrees and extension was 10 degrees. Bilateral lateral bending was 40 degrees. His gait and heel and toe walking were normal. Straight leg raising was negative to 90 degrees while sitting. Sensation to light touch and pinprick were normal. Strength of the lower extremities was 5/5. The Achilles' were 1+ and symmetric. The diagnoses were lumbar sprain, degenerative lumbar intervertebral disc, and displacement of the intervertebral disc. It was felt the patient had reached MMI on 08/14/11 and he was assigned 5% whole person impairment rating. Dr. felt the injury sustained on 12/23/10 extended to include a lumbar sprain/strain. The patient returned to Dr. on 10/10/12. Reflexes were 1+ in the lower extremity and strength was 5/5. Flexion was 75 degrees and extension was less than 5 degrees. On 11/30/12, Dr. noted the patient had been found to be a surgical candidate, but he was having difficulty getting it approved and an IRO was in the process. On 12/23/12, Casereview provided a Notice of Independent Review Decision upholding the previous denials for the outpatient decompressive

surgery with simple laminectomy at L5-S1. On 12/28/12, Dr. reexamined the patient. He continued to have difficulties with his activities of daily living. He had decreased perception of vibration of the left leg, but it was almost absent in the left lateral leg. His reflexes were +1 and strength remained 5/5. Range of motion was unchanged. It was noted the patient wanted to have a second opinion with an orthopedist and he would be referred to, M.D. It was noted the IRO had denied the discectomy and laminectomy. A repeat MRI was recommended at that time. Argus Services Corporation provided a DWC Preauthorization Report and Notification on 01/03/13 noting that the repeat lumbar MRI had been non-authorized. Dr. reexamined the patient on 01/08/13. He still had back pain and left leg pain that radiated to the plantar foot, ankle, and calf. He noted on the right it would radiate to the mid-calf intermittently. It was noted he had been recommended for a decompression at L5-S1. He had left greater than right sciatic notch tenderness and lumbosacral tenderness. He had decreased L5-S1 sensation on the left. Reflexes were symmetric. The CT myelogram was reviewed. An updated lumbar MRI was recommended and Dr. noted that depending on the MRI he might be a candidate for surgery. Argus Services Corporation provided another Preauthorization Report and Notification dated 02/15/13 non-authorizing the requested repeat MRI of the lumbar spine.

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

A repeat lumbar MRI is neither reasonable nor necessary. The patient had his original MRI on 01/12/11. Despite no change in his ongoing symptoms, he had a CT myelogram that was performed on 04/26/12, which again showed no significant pathology. His neurological condition has not changed since that time. As noted by the previous utilization review, that denied the precertification request for the repeat lumbar MRI, there is no progression of neurological findings as required by the ODG to repeat imaging studies. Based upon the ODG, a repeat lumbar MRI is not appropriate due to the fact that there were no changes in his neurological condition 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)