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Notice of Independent Review Decision

Date: February 26, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI lumbar spine with contrast with flexion and extension views

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

Diplomate American Board of Orthopaedic Surgery
Fellowship Trained in Spine Surgery

REVIEW OUTCOME:

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

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 (12/14/12, 01/08/13)
- Office visit (12/03/12)
- Utilization reviews (12/14/12, 01/08/13)
- Diagnostic (07/11/12)
- Office visit (12/03/12)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his low back on xx/xx/xx, while he was lifting a 55-gallon barrel.

No records are available from September 2011 through November 2012, except x-rays of the lumbar spine dated July 11, 2012, which revealed mild disc space narrowing at the L5-S1 level and anterior lateral spurring at the L5 level.

On December 3, 2012, evaluated the patient for low back pain and bilateral leg pain. The patient reported having low back pain that radiated down into the legs mainly on his left side. He had numbness in both legs. His back felt all knotted. His overall pain and weakness had worsened since his last visit. His surgery was denied by Workers Compensation. The patient was eager to return to work and for his symptoms to improve. He had electromyography/nerve conduction velocity (EMG/NCV) of the bilateral lower extremities on April 9, 2012, which was normal. He was utilizing lovastatin, glipizide, Lortab, Flexeril, Celebrex, lisinopril and metoprolol. History was positive for hypercholesterolemia, hypertension, acquired spondylolisthesis, lumbago, lumbar disc displacement and spinal stenosis of the lumbar spine without claudication (onset June 16, 2012). Review of systems (ROS) was positive for numbness, spasms/spasticity, weakness and night sweats. Examination showed tenderness at L4-L5 and L5-S1, 4/5 strength of the left knee extensor and hip flexor secondary to pain, positive straight leg raise (SLR) bilaterally at 20 degrees and positive Patrick's sign bilaterally with back pain, worse on the left. *Magnetic resonance imaging (MRI) of the lumbar spine dated November 7, 2011, showed severe disc desiccation and disc height loss at L4-L5 and L5-S1 with small disc bulges at each level. There was moderate neural foraminal stenosis at L4-L5 bilaterally, mild neural foraminal stenosis at L5-S1 and a grade 1 spondylolisthesis of L4 on L5. X-rays of the lumbar spine dated July 11, 2012, showed L4-L5 and L5-S1 degenerative disc with no signs of instability on flexion/instability and poor flexion on movement.* assessed spinal stenosis of the lumbar spine with claudication, lumbago, lumbar disc displacement and acquired spondylolisthesis. He recommended a posterior L4-s1 laminectomy fusion with a left L4-L5 and L5-S1 transforaminal lumbar interbody fusion (TLIF). He opined that the patient would require a wide laminectomy decompression which would destabilize the facet joints and this would alleviate his lower extremity symptoms and would require the fusion to stabilize the spine and attempt to realign the L4-L5 spondylolisthesis. The patient had been denied multiple treatments and had unsuccessful conservative therapy and hence surgery was the next logical step. ordered MRI of the lumbar spine with flexion/extension and referred the patient to a psychiatrist for clearance for a fusion.

Per utilization review dated December 14, 2012, the request for MRI of the lumbar spine with contrast with flexion and extension views was denied with the following rationale: *"The available clinical information does not support that the request is medically reasonable and necessary. Therefore, the requested services cannot be recommended for authorization at this time. If additional information is provided to me in the future, I would be happy to reconsider this decision. This conclusion is consistent with Official Disability Guidelines (chapter on the low back)".*

Per reconsideration review dated January 8, 2013, the request for MRI of the lumbar spine with contrast with flexion and extension views was denied with the following rationale: *“Based on review of the medical records provided, the proposed treatment consisting of MRI lumbar with contrast with flexion and extension views is not medically necessary. The clinical documentation provided for review notes the claimant complaining of ongoing low back pain. Official Disability Guidelines recommend an MRI of the lumbar region provided that the claimant meets specific criteria, including lumbar spine trauma with neurological deficit, uncomplicated low back pain with radiculopathy and completion of one month of conservative therapy, or cauda equina syndrome. There is a lack of clinical information regarding cauda equina syndrome. Additionally, the claimant is noted to have a radiculopathy component manifested by weakness in the lower extremities. However, there is a lack of clinical information regarding the completion of one month of conservative therapy. Given the lack of clinical information regarding completion of one month of conservative therapy, this request does not meet guideline recommendations. As such, the clinical documentation provided for review does not support this request at this time.”*

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

The records for review begin with a report dated December 3, 2012. It indicates that the patient was being re-referred for evaluation of the low back pain and leg pain bilaterally. The patient has had a work injury on xx/xx/xx, lifting a 55-gallon barrel. The patient reported low back pain that goes into the lower extremities. His back, per patient's report, felt knotted. There is reference to the patient's surgery being denied. There was also a reference to an EMG/nerve conduction on April 9, 2012, of bilateral lower extremities which was normal.

The patient was noted to be a diabetic on glipizide as well as utilizing Lortab, Flexeril, Celebrex, lisinopril and metoprolol.

The patient was reported to have 4/5 strength of the left hip flexor as well as left knee. The patient had 4/5 strength reported for the left knee extensor and left hip flexor, otherwise 5/5 with straight leg raise was only 3 degrees by report bilaterally.

The physical exam noted flexion weakness of the quadriceps, femoral nerve of 4/5 strength in the left lower extremity and 4/5 strength of knee extensor. The reflexes however were considered normal.

The patient had had a previous MRI of November 7, 2011, which showed disc desiccation and disc height loss at L4-L5 and L5-S1 with small disc bulges at each level with foraminal narrowing at L4-L5 bilaterally. There was also reported grade 1 spondylolisthesis of L4 on L5 apparently on the MRI but the lumbar x-rays did not show signs of instability on flexion/extension views.

The patient was advised to seek psychiatrist for clearance for a fusion surgery. Also an MRI of the lumbar spine with flexion-extension was ordered.

There were two URA reviews available. Both of these denied the request for the MRI of lumbar spine with contrast with flexion extension. The comments made included that that there was a prior upright MRI and that the ODG did not recommend this technique.

The reconsideration URA is available for review noting the patient's history and that the patient did not appear to meet ODG criteria. This was reviewed by a neurosurgeon.

Thus in summarization, the ODG criteria for a repeat MRI states that it is not routinely recommended and should be reserved for significant change in symptoms and/or findings suggestive of significant pathology such as recurrent disc herniation or fracture. The patient's need for a contrast MRI is not provided with these records. Moreover, with the EMG being normal and the previous MRI not showing any significant nerve root compression in the central canal but just narrowing of the neural foramen which does not appear to be any worse on the left than the right, the request as submitted does not appear to meet medical necessity. The request is also not consistent with the ODG criteria for an MRI especially with the reference to standing or upright MRI.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
Reference ODG –TWC Low back