**IRO REVIEWER REPORT - WC**

Notice of Independent Review Decision

**April 30, 2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

MRI of the Lumbar Spine with and without contrast between 3/20/13 and 5/19/13.

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

American Board of Neurological 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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- 2-21-11 X-ray of the right elbow
- 2-21-11 X-ray of the sacrum and coccyx

- 2-21-11 X-ray of the left wrist
- 2-21-11 X-ray of the lumbar spine
- 2-21-11, office visit
- 2-23-11, office visit
- 2-25-11 MRI of the lumbar spine
- 3-3-11, office visit
- 3-9-11, office visit
- 3-24-11, office visit
- 3-28-11, office visit
- Physical Therapy on 3-29-11, 3-30-11, 3-31-11, 4-1-11, 4-4-11, 4-6-11, 4-8-11, 4-11-11, 4-12-11, 4-13-11, 4-14-11, 4-15-11, and 4-18-11.
- 4-5-11 office visit
- 4-19-11, office visit
- 4-19-11, office visit
- 4-20-11 Functional Capacity Evaluation.
- 4-22-11, DWC-73
- Work Hardening Program on 4-27-11, 4-28-11, 4-29-11, 5-2-11, 5-3-11, 5-4-11, 5-5-11, 5-6-11, 5-9-11, 5-11-11, 5-24-11, 5-25-11, 5-26-11, 6-1-11, 6-2-11, 6-3-11, 6-6-11, 6-7-11, 6-8-11, and 6-9-11.
- 5-16-11, Letter of Medical Necessity.
- 6-1-11 DO, office visit
- 6-13-11 Functional Capacity Evaluation.
- 6-21-11, DWC-73
- 6-23-11, office visit

- 6-28-11, office visit
- 7-6-11, DWC-73
- 7-20-11, Impairment Rating
- 8-3-11, office visit
- Physical Therapy on 8-8-11, 8-10-11, 8-15-11, 8-17-11, 8-18-11, and 8-22-11.
- 8-15-11, office visit
- 8-19-11, surgery
- 8-19-11 CT of the lumbar spine
- 8-19-11 Lumbar myelogram
- 8-24-11, office visit
- 9-6-11 EMG-NCV
- 9-14-11, office visit
- 9-15-11, office visit
- 9-17-11 , DWC-73
- Pain Management Program on 10-3-11, 10-4-11, 10-5-11, 10-6-11, 10-10-11, 10-11-11, 10-12-11, 10-13-11, 10-17-11, 10-18-11, 10-26-11, 10-27-11, 10-28-11, 11-2-11, 11-3-11, 11-4-11, 11-9-11, 11-10-11, 11-11-11, and 11-15-11.
- 10-12-12, office visit
- 10-19-11, Letter of Medical Necessity.
- 10-20-11, office visit
- 11-17-11, office visit
- 11-17-11 Functional Capacity Evaluation.
- 12-1-11, Impairment Rating.

- 12-15-11, office visit.
- 1-3-12 , DWC-73
- 1-12-12, 2-13-12, office visit
- 3-7-12, office visit
- 3-15-12, office visit
- 4-10-12, surgery
- 5-14-12 X-ray of the lumbar spine
- 5-14-12, office visit
- Physical Therapy on 5-21-12, 5-22-12, 5-24-12, 5-29-12, 5-30-12, 5-31-12, 6-5-12, 6-6-12, 6-7-12, 6-11-12, 6-12-12, 6-14-12, 6-18-12, 6-19-12, 6-20-12, and 6-28-12.
- 7-12-12 X-ray of the lumbar spine
- 7-12-12 MD, office visit
- 7-13-12 DC, office visit
- 7-17-12 Unknown Provider, office visit
- 7-17-12 Functional Capacity Evaluation.
- Pain Management Program on 7-30-12, 7-31-12, 8-1-12, 8-2-12, 8-7-12, 8-8-12, 8-9-12, 8-10-12, 8-13-12, 8-15-12, 9-4-12, 9-5-12, 9-6-12, 9-7-12, 9-10-12, 9-17-12, 9-24-12, 9-25-12, 9-26-12, and 9-27-12.
- 8-14-12, office visit
- 8-30-12 ESIS: Utilization Review Determination.
- 9-11-12, office visit
- 10-15-12, office visit
- 10-16-12, Impairment Rating.

- 10-29-12 EMG-NCV
- 10-30-12: Utilization Review Determination
- 11-16-12 CT of the lumbar spine without contrast
- 12-6-12, office visit
- 2-1-13, DWC-73
- 2-7-13, office visit
- 2-28-13 X-rays of the lumbar spine flexion extension.
- 3-11-13, office visit
- 3-19-13, performed a UR
- 3-25-13, UR non certification for MRI of the lumbar spine.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

2-21-11 X-ray of the right elbow, showed no acute abnormality is identified of the right elbow.

2-21-11 X-ray of the sacrum and coccyx, showed no acute abnormality of sacrum and coccyx is identified.

2-21-11 X-ray of the left wrist, showed no acute radiographic abnormality of the left wrist.

2-21-11 X-ray of the lumbar spine, showed degenerative changes are present in the lumbar discs and facet joints. No acute abnormality is evident.

2-21-11 FNP., the claimant is here today with complaints of low back pain and tailbone pain, right elbow pain and left wrist pain all secondary to a hit from a pair of tongs on a xx, all of which occurred on xx. The claimant states that he was hit with the tongs across the lower back. It knocked him down off the floor of the drilling rig to the ground at which time he slid. He states his elbow on the right side and his left wrist both have hurt as well as has lower back and his tailbone since the time of incident. He utilized OTC anti-inflammatory and has been at home but states that the pain has continued to be worse. Pain as increased when he attempts to sit, especially for any long periods of time. The pain does radiate mildly from the lower back into the right posterior leg and then wraps into the anterior portion of the thigh. He has mild tangling sensation noted in the right anterior thigh traveling to gust

above the knee. The lower leg feels normal. Body part has never been injured in the past. Last tetanus shot is unknown. Assessment: Lumbar strain, contusion, multiple contusions. Plan: Return to work modified status 2-21-11. X-rays right elbow, left wrist lumbar and coccyx today. The claimant was prescribed Soma, Anaprox. Heat pack and Flexall today and tomorrow. Follow-up on Wednesday or Thursday. Send donut home with the claimant for seating comfort. Utilization of cold pack to the lower lumbar area post warm shower. Instructions are given to the claimant and discussed with his safety officer. DWC-73: The claimant was returned to work from 2-21-11 with restrictions.

2-23-11 FNP., the claimant complains of low back pain. Assessment: Lumbar strain and multiple contusions. Plan: Return to modified duty. Those restrictions are the same as previously outlined and on separate cover to review. His mother asked several times if he can be taken off work as his pain is getting worse. The evaluator told him that if his employer is unable to meet these requirements, that is the employer's responsibility. However, her restrictions apply to work and home. An MRI is ordered of the lumbosacral area. The evaluator will call him with the results and schedule follow-up as needed. Force fluids and eat fiber food to avoid constipation. Take meds with food. If he notices the Anaprox upsets his stomach despite taking it with food, he should discontinue. He states he has had limited relief of symptoms using the donut pillow, but the evaluator told him to use it p.r.n. DWC-73: The claimant was returned to work from 2-23-11 with restrictions.

2-25-11 MRI of the lumbar spine, showed broad based posterior disk bulging present at the L5-S1 encroaches on the left neural foramen effacing the paraneural fat and fascia and possibly causing some mild impingement on the exiting left nerve root. Otherwise normal MRI of the lumbar spine.

Follow-up visit on 3-3-11 notes the claimant referred to neurosurgery for evaluation and treatment for the disc bulge. Continue use of OTC anti-inflammatory as needed by the claimant.

3-9-11, the claimant complains of low back pain. Assessment/Plan: The evaluator told claimant that at this point in time he thinks that he has sustained some bony edema at L5-S1 as a result of injury. This is likely to subside with time and with limited activities. The evaluator have given him a release to return to work with limited activities. The evaluator told him to follow up in six weeks time. At that point in time the evaluator will reevaluate his condition and make further recommendations. He understands to contact the offices if his condition should worsen.

3-24-11, the claimant presents for evaluation and treatment of injuries he reportedly sustained while at work on xx/xx/xx. At the time of the injury he was employed by xx. Following is the claimant's description of his injury as well as a brief listing of the results of his examination findings. The claimant was struck in the back by the drilling tongs and fell 7 feet to the deck. He was seen by xx and referred. Plan: After

completing an initial examination and evaluation of the claimant, the evaluator has selected a plan of treatment that should return this claimant to a pre-injury status and minimize the possibility of future permanent residuals. Treatment will consist of therapy three times per week for four weeks Therapy will consist of therapeutic exercise. DWC-73: The claimant was taken off work from 3-24-11 through 4-22-11.

3-28-11, the claimant presents today upon referral., who is his new treating doctor. Review of records, including MRI. The claimant states that he was injured on xx/xx/xx, while working as a motorman for. States that he was injured when he was "hit in the (lumbar) back with tongs while in the oil field." Describes the pain as stretching pinching pain, with achy sensations into the legs. States that since the injury he has difficulty getting out of bed in the morning as well as other complications of immobility. Denies any incontinence. The pain also radiates into the buttocks, with the right side being worse than the left. Also notes numbness across the lumbar back. He states that he is allergic to Lortab (causes rash). The evaluator will prescribe: Prednisone 50 mg. Also recommending McKenzie exercise. Dr. will order active therapy as well as referring to Dr for an ESI. Will follow up next week.

Physical Therapy from 3-29-11 through 4-18-11 (13 sessions)

4-5-11, the claimant follows up today. He has been participating in physical therapy; however, he states that the Prednisone did not help at all. He continues to have rather significant pain. He is not working at this time. Therefore, the evaluator will prescribe Tramadol. He states that he is doing McKenzie exercises. He is scheduled to see Dr. for consultation on 4-10. Will follow up next week.

4-19-11, the claimant complains of low back pain. Assessment/Plan: At this point in time, the evaluator has recommended left-sided epidural steroid injections at L5-S1 as well as continued physical therapy. The evaluator will await notification from Worker's Compensation as to whether this is approved or denied. Once the evaluator receives this information he will contact the claimant. The risks and benefits of the procedure were discussed with him including bleeding, infection, injury to the nerves, numbness, weakness, paralysis and failure to improve. The evaluator discussed meningitis, CSF leak and how these would be treated.

4-19-11, , the claimant presents for a Psychological Evaluation. Diagnosis: Axis I: Pain Disorder Associated with a General Medical Condition. Axis II: Deferred. Axis III: 724.2 722.10 724.3 729.1. Axis IV: Psychological stressors: 3, moderately severe chronic pain producing disruption of physical function unable to return to work financial stressors. Axis V: GAF: Current: 65%. Plan: The evaluator recommends that the claimant be admitted to the Work Hardening Program for 10 days, 8 hours a day During the first 10 days, a review of progress will be made. If treatment goals are being met, additional sessions may be recommended. If treatment goals are not being met, other options will be considered at that time based upon his general level of functioning.

4-20-11 Functional Capacity Evaluation shows the claimant is functioning at a .

4-22-11, DWC-73: The claimant was taken off work from 4-22-11 through 5-20-11.

Work Hardening Program from 4-27-11 through 6-9-11 (20 sessions)

5-16-11, the evaluator noted that the treatment team recommends that the claimant continue his participation in the Work Hardening Program for 10 days in order to enhance the process of recover he has begun. The focus is now to accelerate the pace of progress, solidify sleeping patterns, decrease narcotic medication intake and increase the level of activity to a demand level that he can return to work and a more functional lifestyle. Once the pain levels decrease and functioning increases, he should see significant relief of depressed mood arid anxiety. During the first 10 days of the program, the Global Assessment of Functioning (OAF) has increased slightly from 65% to 70%, while the psychosocial stressors have decreased to 3, related to pain, unemployment and financial stressors. He expresses helplessness and hopelessness about increasing his function and control of the pain. He participates in claimant teaching, individual and group therapy. The initial BDI and BAT were 16 and 18, respectively. The inventories taken after 10 days: BDI: 21 and BAI: 20. The testing reflects pessimism, sadness, logs of pleasure, loss of interest, loss of energy, changes in sleeping pattern, indecisiveness, difficulty with concentration, fatigue, irritability as well as an loss of interest in sex. The anxiety inventory reflects inability to relax, numbness and tingling and fear of the worst happening and dizziness. The goals of the program include stabilizing the depression and anxiety inventories, increasing GAF to 85% and further decreasing psychosocial stressors to 0.

6-1-11, the claimant presents today telling the evaluator that he still feels a substantial degree of low back pain. The evaluator has tried an epidural steroid injection which was not very helpful for him, thus he will not proceed with any further injections. He tells the evaluator that he has intermittent diarrhea and feels that he has some blood in his stools occasionally. He describes this as what might be consistent with hemorrhoids. He does not have constipation and he does not have incontinence of his bowel. At this point in time the evaluator thinks he would be best served with nonsurgical measures including pain management. Assessment/Plan: The claimant has low back pain resulting from his degenerative disk disease. It would be prudent that the evaluator try pain management and other nonsurgical measures at this point in time, given his young age of xx years. If those measures should fail, the evaluator told him to call the office and he would reinitiate evaluation. However at this point in time he will follow up on a p r n basis, as the evaluator does not think surgery is in his immediate future.

6-13-11 Functional Capacity Evaluation shows the claimant is functioning at a Light-Medium PDL.

6-21-11, , DWC-73: The claimant was taken off work from 6-21-11 through 7-6-11.

6-23-11 MD., the claimant was injured while working at on xx/xx when he got struck in the lower back with tongs. He has had severe low back pain and bilateral radiating hip and leg pain since that time. There is no previous history of a lumbar problem. He went back to work at light duty for two weeks, but got much worse and has not worked since that time. He has a feeling of numbness and dysesthems in the legs in addition to the pain. His pain is aggravated by walking, standing, and activities. He has had chiropractic care and physical therapy. An epidural steroid injection did not help. He has been on hydrocodone and Flexeril. Lumbar MR scan done six days after his injury showed a broad-based disc protrusion at L5-S1, mainly to the left, with otherwise normal MR scan. He has no lower abdominal pain or sphincter abnormalities. He has a severe lumbosacral strain/contusion problem with superimposed L5-S1 disk herniation with a chronic mechanical low back disorder and radiculopathies. Treatment options were discussed with him. He has failed to improve with conservative measures. The next step will be lumbar myelography and post-myelographic CT scanning for further investigation. He is to continue with his chiropractic care. The evaluator gave him Ultracet, Flexeril, and Motrin. He will be seen in follow-up. DWC-73: The claimant was taken off work from 6-23-11 through 7-23-11.

Follow-up visit with Dr. on 6-28-11 notes the claimant has been seen by Dr. and is awaiting approval for a myelogram.

7-6-11, DC., DWC-73: The claimant was taken off work from 7-6-11 through 8-3-11.

7-20-11, DO., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 10-20-11 as the date of MMI. The claimant's ranges of motion measurements show that he has made and is continuing to make improvements, which supports the conclusion of him not being at MMI at this time.

Follow-up visit with Dr. on 8-3-11 notes the claimant continues to have back pain. He has a follow-up scheduled with Dr.. The evaluator will ask for preauthorization of six sessions of physical therapy to reemphasize his home exercise program and bring his pain levels down.

Physical Therapy from 8-8-11 through 8-22-11 (6 sessions)

8-15-11., MD., the claimant was seen two months ago. The evaluator is trying to get approval for a lumbar myelogram and post-myelogaphic CT scan because of his continued severe lumbosacral pain and bilateral radiating hip and leg pain. His injury was six months ago and he is actually getting worse in spite of good conservative measures. He walks with a flexed posture to the low back Straight leg raising is positive bilaterally at less than 45 degrees He has depressed ankle reflexes and has difficulty toe standing and heel standing bilaterally. The Ultram does not give him any benefit and he was placed on hydrocodone 7 5 mg. He also takes Flexeril and Motrin. This claimant is incapacitated and has a positive MR scan at L5-S1 and because of failure to improve with good conservative measures after six months, it is

time to proceed with a lumbar myelogram and post-myelographic CT scan. The evaluator will continue to try to get the procedures approved.

8-19-11 MD., procedure performed: Lumbar myelogram.

8-19-11 CT of the lumbar spine performed by MD., showed multilevel degenerative change from L3 to L5-S1.

8-19-11 Lumbar myelogram performed by MD., showed thecal sac deformity.

8-24-11 MD., the claimant continues to have severe lumbosacral pain with mainly left leg radicular pain: Myelogram and CT scan show a central L4-5 defect, exacerbate by tension of the back, with very narrow degenerative L5-S1 disk space with root compression at that level, mainly on the left side. CT scan confirmed the MR Scan, showing mainly the central defect at L5-S1 with compression of the left L5 and Si roots. There is a disc herniation on the left at L5-S1 with compression of the root. His major problem does appear to be at L5-S1 with left-sided L5 and S1 root compression, secondary to the herniated disk, post-traumatic. He is getting electrophysiologic studies of the lower extremities at your office in about two week and the evaluator will see him after that and discussion of treatment options will be made. He may well need a left L5-S1 laminectomy with excision of herniated disk and root compression. He continues to take hydrocodone 7.5 .mg, Flexeril, and Motrin. He has a follow-up visit to the office after electrophysiologic studies are done.

9-6-11 EMG-NCV performed by DO., showed there is electrophysiological evidence of moderate chronic denervatical patterns occurring in the lower lumbar paraspinal muscle region bilaterally. There is also evidence of mild-moderate chronic denervation patterns as well as some reinnervation occurring in L5-S1 innervated muscles of both lower extremities. These electro diagnostic findings coupled with sensory sparing as well as peroneal and tibial motor nerve temporal dispersion are therefore, most likely consistent with an L5-S1 radiculopathy occurring bilaterally of moderate severity left worse than right.

Follow-up visit with Dr. on 9-14-11 notes the evaluator is currently waiting on an orthopedic consultation with Dr..

9-15-11 MD., the claimant is having increasingly severe lumbosacral pain and bilateral radiating hip and leg pain, worse on the left. He has a severe post-traumatic L5-S1 disk problem with a very narrow disk space with root compression, mainly on the left side. All of his diagnostic studies, including MR scan and lumbar myelogram and CT scan, show the severe problem at L5-S1. Electrophysiologic studies were abnormal. He has had physical therapy and chiropractic care and has had steroid-injections and continues to require medications including Hydrocodone, Flexeril, and Motrin. He walks with  a flexed posture at the low back. Straight leg raising is positive on the right at 45 degrees and on the left at 30 degrees. Ankle reflexes are

depressed. This claimant is incapacitated and will require a L5-S1 decompression, fusion and instrumentation for treatment of his problem. The evaluator will start the approval process.

9-17-11 DC., DWC-73: The claimant was taken off work from 9-17-11 through 10-17-11.

Pain Management Program from 10-3-11 through 11-15-11 (20 sessions)

10-12-12 W. Ph.D., the claimant presents for a Psychological Evaluation. Diagnosis: Adjustment disorder with depressed mood psychosocial stressors: severity 3-moderate. Global Assessment of Functioning: Current GAF- 68. Plan: The claimant benefiting from rehabilitation programs.

10-19-11 MD., the evaluator noted that the treatment team recommends that the claimant continue his participation in the Pain Management Program for 10 days in order to enhance the process of recovery he has begun. The focus is now to prevent surgery by accelerating the pace of progress, solidifying sleeping patterns, decreasing narcotic medication intake and increasing the level of activity to a demand level that he can return to work and a more functional lifestyle. Once the pain levels decrease and functioning increases, he should see significant relief of depressed mood and anxiety.

10-20-11 MD., the claimant had a psychological evaluation. He has had all forms of conservative measures. Chiropractic care does give him some temporary relief. All of his studies show severe post-traumatic disease at L4-5 and L5-S1 with disc protrusions, root compression, and narrow disc spaces. He has had epidural steroid injections and multiple medications. The evaluator could find no differences on his spinal or neurologic examination. These examinations do show very severe lumbosacral disc pathology with diminished mobility, tenderness over the sciatic outlets, loss of lumbar lordosiss paralumbar muscular tightness and positive Straight leg raising bilaterally. This claimant wants to go back to work, but-is incapacitated. He takes hydrocodone 7.S mg Flexeril, and Motrin. This claimant needs posterior L4-5 and L5-S1 decompression, fusion, and instrumentation to treat his severe mechanical low back disorder and to relieve his radiculopathies. For unknown reasons, his problem is listed as a lumbar strain which is absolutely wrong. He obviously has post-traumatic two-level disk pathology. The evaluator feels that he needs to hold worker's comp and its reviewers liable for any chronic mechanical lumbar syndrome or permanent radiculopathies that this claimant has because of failure to timely allow for his much-needed surgery.

11-17-11 MD., the evaluator noted that for unknown reasons, the proposed surgery on the claimant was again denied; even though he has severe post-traumatic disease at L4-5 and L5-S1, with herniated disk, stenosis, and root compression. He has failed all forms of conservative measures. The evaluator did refill Hydrocodone, Flexeril and Motrin. The evaluator will request lumbar diskography at L3-4, L4-5,

and L5-S1 for further diagnostic studies since the evaluator is unable to get his much-needed surgery approved.

11-17-11 Functional Capacity Evaluation shows the claimant is functioning at a Light PDL.

12-1-11 DO., performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 3-1-12 as the date of MMI. The claimant has not been afforded adequate opportunity of care for his injuries and has received appropriate care, but has not fully recovered to a level where he has reached MMI.

Follow-up visit with Dr. on 12-15-11 notes the claimant was continued with medications.

1-3-12 DC., DWC-73: The claimant was taken off work from 1-3-12 through 3-4-12.

Follow-up visit with Dr  on 1-12-12 and 2-13-12 notes the claimant was continued with medications.

3-7-12 MD., the claimant complains of low back, right elbow, and left wrist. Assessment: Lumbar herniated nucleus pulposus, lumbar radiculitis right lower extremity. Plan: This claimant will continue his hydrocodone. The evaluator would like to add Neurontin 140 mg twice daily and tizanidine in the evening. The evaluator will see if this would help pain and functional status as he moves forward with his surgical dispute.

3-15-12 MD., the claimant was seen for follow-up in the office today. Worker's comp has approved his L5-S1 posterior decompression, fusion, and instrumentation. The evaluator is awaiting final approval from the adjuster. He has also been approved for a lumbosacral brace. He continues to get worse. He has very severe two level disease with stenosis, herniated disk, and root compression. He needs L4-5 and L5-S1 decompression, fusion, and instrumentation. He has increasing numbness and weakness in the lower extremities and he walks with a flexed posture to the low back with positive straight leg raising at less than 45 degrees with weakness of plantar flexion. The evaluator refilled Hydrocodone, Flexeril and Motrin.

4-10-12 MD., preoperative and postoperative diagnosis: Severe post-traumatic L4-L5 and L5-S1 disk pathology, L4-L5 and L5-S1 disk herniations and stenosis, chronic mechanical low back disorder, lumbar radiculopathies with neurologic deficit. Procedure: Decompressive L4 through S1 laminectomy. Bilateral L4, L5, and S1 root decompression with opening of lateral recesses and foraminotomies. Bilateral L4-L5 and L5-S1 excision of herniated disk with root decompression. Bilateral L4-L5 and L5-S1 anterior spinal column arthrodesis, interbody technique. Bilateral L4-L5 and L5-S1 interbody cage implants. Bilateral L4 through S1 posterolateral fusion. Morselized autograft. Bilateral L4, L5, and S1 pedicle screws and rods with cross-link. BI spinal fusion stimulator. On-Q subcutaneous Naropin infusion catheter.

5-14-12 X-ray of the lumbar spine performed by MD., showed post-op lumbar spine without acute abnormality.

Follow-up visit with Dr. on 5-14-12 notes the evaluator will submit for 18 sessions of post operative active therapy. His goal being to decrease pain and increase functional levels.

Physical Therapy from 5-21-12 through 6-28-12 (16 sessions)

7-12-12 X-ray of the lumbar spine performed by MD., showed post-op lumbar spine without acute abnormality.

7-12-12 MD., the claimant is three months after his L4-5 and L5-S1 surgery. X-rays show good position of the instrumentation with progressive interbody and posterolateral fusion with good alignment. He has some residual right leg discomfort from the severe root compression that he had prior to surgery. He will take Hydrocodone, Flexeril, Motrin and will add Cymbalta. He is to continue with your treatments. He is otherwise doing very well. He is not ready to return to work. He has a follow-up visit in 3 months with x-rays.

Follow-up visit with Dr. on 7-13-12 notes the evaluator will submit for chronic pain program.

7-17-12 Unknown Provider, the evaluator noted that the results of this assessment suggest that the claimant is experiencing persistent pain that has prevented him from return to work, in addition to mounting frustration about how to cope with the complications of immobility. To help the claimant control his level of distress and pain and maximize his ability to return to work and sustain a productive lifestyle, it is recommended that he be admitted to a Work Hardening Program. A cognitive-behavioral approach will be utilized with emphasis on relaxation skills and behavioral modification for sleep disturbance and pain management. The recommended clinical services would enable him to learn to cope with pain and prevent further development of his feelings of disability. The therapy will maximize his chances for return to a more optimal level of functioning and an enhanced quality of life, with perhaps, some possibility of return to work.

7-17-12 Functional Capacity Evaluation shows the claimant is functioning at a

Pain Management Program from 7-30-12 through 9-27-12 (20 sessions)

8-14-12 DC., the evaluator noted that the treatment team recommends that the claimant continue his participation in the Pain Management Program for 10 days in order to enhance the process of recovery he has begun. The focus is now to accelerate the pace of progress in physical functioning, solidifying sleeping patterns, decreasing narcotic medication intake and increasing the level of activity to a

demand level that he can return to work and a more functional lifestyle. Once the pain levels decrease and functioning increases, he should see significant relief of depressed mood and anxiety.

8-30-12 ESIS: The prospective request for 40 Hours of Chronic Pain Management Program between 8-28-12 and 10-27-12 is certified.

9-11-12 DC., the evaluator noted that the treatment team recommends that the claimant continue his participation in the Pain Management Program for 5 days in order to enhance the process of recovery he has begun. The focus is now to accelerate the pace of progress in physical functioning, solidifying sleeping patterns, decreasing narcotic medication intake and increasing the level of activity to a demand level that he can return to work and a more functional lifestyle. Once the pain levels decrease and functioning increases, he should see significant relief of depressed mood and anxiety.

10-15-12 MD., the claimant is six months after his L4-5 and L5-S1 surgery for treatment of severe post-traumatic disease. He still has some residual lumbar pain and right leg pain. He may have a little weakness in his right foot. He needs chiropractic treatments by you for his lumbar discomfort. He still takes hydrocodone, Flexeril and Motrin. He was unable to tolerate the Cymbalta and will be placed on Neurontin 400 mg Worker's comp would not allow any x-rays today and the evaluator will ask for approval for AP and lateral lumbar spine x-rays and also a lumbar CT scan to further evaluate the reason for his right leg discomfort. He will be seen in follow-up.

10-16-12 MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI on 10-10-12 and awarded the claimant 10% whole person impairment. DWC-73: The claimant was returned to work from 8-22-12 through present with restrictions.

10-29-12 EMG-NCV performed by MD., showed abnormal EMG findings of the right tibial innervated muscles indicate a possible nerve root irritation at the right S1 level, which is consistent with a radiculopathy at this time. Further clinical correlation is indicated.

10-30-12 ESIS: CT Scan of the Lumbar Spine without Contrast between 10-29-12 and 12-29-12. This is an appeal to review 136313.

11-16-12 CT of the lumbar spine without contrast performed by MD., showed post-op lumbar spine with no evidence of acute radiographic abnormality.

12-6-12 MD., the claimant was seen in the office today. He was seen two months ago. CT scan of the lumbar spine did not show any herniated disk or stenosis and showed normal postoperative changes. He is now almost eight months after his surgery. The treatments are helping him. He continues with hydrocodone 10 mg,

Flexeril, Motrin, and Neurontin. He is gradually increasing his activities. He has a follow-up visit in two months with x-rays.

2-1-13 DC., DWC-73: The claimant was taken off work from 2-1-13 through 3-1-13.

2-7-13 MD., the claimant tried returning to work but had increasing lumbar pain. He does not have true radicular leg pain and strength in his legs is normal. However, the evaluator was concerned that he had some instability at the L3-L4 level. Lumbar flexion/extension x-rays will be requested.

2-28-13 X-rays of the lumbar spine flexion extension showed alignment was normal. PLIF has been performed from L4 to S1. Disc spaces are present. Bone stimulator is present. No abnormal lucency about the hardware is noted. There is preservation of the vertebral body heights. Minimal endplate degenerative changes present at L1-L2, L2-L3, L3-L4. Sclerotic areas overlie the right iliac wing, which are unchanged and probably related to bone island. No pars defects are demonstrated. No significant translation is noted with flexion and extension.

3-11-13 MD., the claimant was seen for follow-up. X-rays with flexion and extension were done. He has narrowing of the disc space at L3-L4 with some retrolisthesis with what appears to be at least some movement with flexion/extension films. He has mechanical pain in the low back, exacerbated by walking, standing, and activities with paralumbar muscular tightness and some loss of lumbar lordosis. The evaluator requested an MRI of the lumbar spine to look for any root compression, stenosis or herniated disc at L3-L4 level. He still takes Hydrocodone, Zanaflex, Motrin, and Neurontin. He is not able to work at the present time.
3-19-13 Vinson Disanto, DO., performed a UR. He noted that the request for MRI was not certified. He noted that there was an absence of a comprehensive neurological examination that documents significant clinical findings suggestive of pathologies at L3-L4. Also, implementation of active rehab treatments, particularly after the increased symptoms noted during the 2-7-13 evaluation was not reported. In the absence of recent objective findings suggestive of progressive neurological compromise, the medical necessity of this request is not substantiated at this time.

3-25-13 MD., UR non certification for MRI of the lumbar spine. The evaluator reported that the clinical information does not provide further information as to why an MRI would be needed to be performed and did not indicate that the CT scan was not sufficient to support additional imaging at this time.

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

Medical records reflect a claimant status post PLIF L4-L5 and L5-S1. The treating physician notes the claimant has mechanical pain in the low back, exacerbated by walking, standing, and activities with paralumbar muscular tightness and some loss

of lumbar lordosis. The treating doctor requested an MRI of the lumbar spine to look for any root compression, stenosis or herniated disc at L3-L4 level. Based on the records provided, there is an absence in documentation to support the requested MRI. There is no documentation of radicular findings on exam. ODG would not support an MRI at this juncture. Therefore, MRI of the Lumbar Spine with and without contrast between 3/20/13 and 5/19/13 is not reasonable or medically necessary.

**Per ODG 2013 MRI:** Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. 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). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. The ease with which the study depicts expansion and compression of the spinal cord in the myelopathic patient may lead to false positive examinations and inappropriately aggressive therapy if findings are interpreted incorrectly. (Seidenwurm, 2000) There is controversary over whether they result in higher costs compared to X-rays including all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003) In addition, the sensitivities of the only significant MRI parameters, disc height narrowing and anular tears, are poor, and these findings alone are of limited clinical importance. (Videman, 2003) Imaging studies are used most practically as confirmation studies once a working diagnosis is determined. MRI, although excellent at defining tumor, infection, and nerve compression, can be too sensitive with regard to degenerative disease findings and commonly displays pathology that is not responsible for the patient's symptoms. With low back pain, clinical judgment begins and ends with an understanding of a patient's life and circumstances as much as with their specific spinal pathology. (Carragee, 2004) Diagnostic imaging of the spine is associated with a high rate of abnormal findings in asymptomatic individuals. Herniated disk is found on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging disks, in 20% to 81%; and degenerative disks, in 46% to 93%. (Kinkade, 2007) Baseline MRI findings do not predict future low back pain. (Borenstein, 2001) MRI findings may be preexisting. Many MRI findings (loss of disc signal, facet arthrosis, and end plate signal changes) may represent progressive age changes not associated with acute events. (Carragee, 2006) MRI abnormalities do not predict poor outcomes after conservative care for chronic low back pain patients. (Kleinstück, 2006) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as magnetic resonance imaging (MRI) without a clear rationale for doing so. (Shekelle, 2008) A new meta-

analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. (Chou-Lancet, 2009) Despite guidelines recommending parsimonious imaging, use of lumbar MRI increased by 307% during a recent 12-year interval. When judged against guidelines, one-third to two-thirds of spinal computed tomography imaging and MRI may be inappropriate. (Deyo, 2009) As an alternative to MRI, a pain assessment tool named Standardized Evaluation of Pain (StEP), with six interview questions and ten physical tests, identified patients with radicular pain with high sensitivity (92%) and specificity (97%). The diagnostic accuracy of StEP exceeded that of a dedicated screening tool for neuropathic pain and spinal magnetic resonance imaging. (Scholz, 2009) Clinical quality-based incentives are associated with less advanced imaging, whereas satisfaction measures are associated with more rapid and advanced imaging, leading Richard Deyo, in the Archives of Internal Medicine to call the fascination with lumbar spine imaging an idolatry. (Pham, 2009) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the Journal of the American College of Radiology. There were high rates of inappropriate examinations for spinal CTs (53%), and for spinal MRIs (35%), including lumbar spine MRI for acute back pain without conservative therapy. (Lehnert, 2010) Degenerative changes in the thoracic spine on MRI were observed in approximately half of the subjects with no symptoms in this study. (Matsumoto, 2010) This large case series concluded that iatrogenic effects of early MRI are worse disability and increased medical costs and surgery, unrelated to severity. (Webster, 2010) Routine imaging for low back pain is not beneficial and may even be harmful, according to new guidelines from the American College of Physicians. Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. (Chou, 2011) The National Physicians Alliance compiled a "top 5" list of procedures in primary care that do little if anything to improve outcomes but excel at wasting limited healthcare dollars, and the list included routinely ordering diagnostic imaging for patients with low back pain, but with no warning flags, such as severe or progressive neurologic deficits, within the first 6 weeks. (Aguilar, 2011) Owning MRI equipment is a strongly correlated with patients receiving MRI scans, and having an MRI scan increases the probability of having surgery by 34%. (Shreibati, 2011) A considerable proportion of patients may be classified incorrectly by MRI for lumbar disc herniation, or for spinal stenosis. Pooled analysis resulted in a summary estimate of sensitivity of 75% and specificity of 77% for disc herniation. (Wassenaar, 2011) (Sigmundsson, 2011) Accurate terms are particularly important for classification of lumbar disc pathology from imaging. (Fardon, 2001) Among

workers with LBP, early MRI is not associated with better health outcomes and is associated with increased likelihood of disability and its duration. (Graves, 2012) There is support for MRI, depending on symptoms and signs, to rule out serious pathology such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care, are also candidates for lumbar MRI to evaluate potential for spinal interventions including injections or surgery. For unequivocal evidence of radiculopathy, see AMA Guides. (Andersson, 2000) MRI with and without contrast is best test for prior back surgery. (Davis, 2011) See also ACR Appropriateness Criteria™. See also Standing MRI.
Recent research: More than half of requests for MRI of the lumbar spine are ordered for indications considered inappropriate or of uncertain value, pointing to evidence of substantial overuse of lumbar spine MRI scans. For family physicians, only 34% of their MRI scans were considered appropriate vs 58% of those ordered by other specialties. On the other hand, the vast majority of MRIs ordered for headaches, 83%, were deemed appropriate. (Emery, 2013) This study casts doubt on the value of post-op spinal imaging for patients with sciatica, because it could not distinguish those with a favorable clinical outcome from those with persistent symptoms. Disk herniation was visible in 35% of patients with a favorable outcome and in 33% with an unfavorable outcome, and nerve root compression was present in 24% of those with a favorable outcome and in 26% of those with an unfavorable outcome. They concluded that the MRI scan does not have any discriminatory power at all. Irrelevant findings have the potential to frighten patients and initiate cascades of unnecessary testing or intervention, with occasional risks. The study showed that neither a herniated disk nor the presence of scar tissue on MRI was associated with patient outcome, but these findings may lead to unnecessary further imaging and surgery. (el Barzouhi, 2013)

**Indications for imaging -- Magnetic resonance imaging:**
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated low back pain, suspicion of cancer, infection, other “red flags”
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.
- Uncomplicated low back pain, prior lumbar surgery
- Uncomplicated low back pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, stepwise progressive
- Myelopathy, slowly progressive
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

**IRO REVIEWER REPORT - WC**

**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)**