

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** August 6, 2014

**IRO CASE #:**

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

MRI Lumbar without contrast

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

The reviewer is certified by the American Board of Orthopaedic Surgery with over 42 years of experience.

**REVIEW OUTCOME:**

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

Overturned (Disagree)

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who injured his back while working on xx/xx/xx.

04/27/13: MRI Lumbar Spine report. IMPRESSION: Straightening of the normal lordosis of the lumbar spine, nonspecific, but under the clinical setting of lower back pain, can be related to muscle spasm. Disc dehydration with circumferential disc bulge and 2 mm posterior central disc protrusion with associated posterior central annular tear at L3-L4 resulting in mild central canal stenosis and mild bilateral lateral recess and neural foraminal narrowing at L4-L5. Circumferential disc bulge with disc dehydration at L5-S1, also with associated mild central canal stenosis, bilateral lateral recess narrowing, and mild-moderate bilateral L5-S1 neural foraminal narrowing, in which the disc bulge appears to be in contact with the bilateral exiting L5 nerve roots.

05/20/13: The claimant was evaluated for low back pain, left leg pain, paresthesias, and numbness. It was noted that he had seen for therapy and had a fairly significant course of therapy but continued to complain of pain. On exam, his gait was very slow and antalgic. Range of motion of the lumbar spine was

limited more so in flexion and extension. SLR was positive at about 30 degrees on the left. He had mild strength loss in the left EHL and tibialis anterior at 4/5. The impression was L5-S1 HNP with probable left L5 radiculopathy. An EMG of the left lower extremity was recommended as well as lumbar epidural steroid injection.

06/17/13: The claimant was re-evaluated and had electrodiagnostic testing of the lumbar spine and lower extremities. OVERALL IMPRESSION: Abnormal studies. Electrodiagnostic evidence of left L5 radiculopathy. No evidence of any other entrapment neuropathy, plexopathy, or peripheral neuropathy. L5-S1 HNP with left L5 radiculopathy secondary to work-related injury. He was scheduled for a lumbar epidural steroid injection and was to continue Lyrica.

01/23/14: The claimant was evaluated for low back pain. He had been taking hydrocodone with minimal relief. His low back pain radiated into the left lower extremity, worse with standing. Review of lumbar flexion/extension x-rays demonstrated anterior osteophytes with endplate changes at L4-L5, loss of posterior disc height most noted at L5-S1, no spondylolisthesis or compression fracture, no scoliosis. Assessment was weakness at 4/5 in the left anterior tibialis and EHL. Tension signs positive on the left leg only. Impression was aggravation of a chronic underlying degenerative condition which was clinically silent before the accident. The plan was for a preoperative assessment. He was given a prescription for Norco 10/325 mg.

02/24/14: The claimant was evaluated. It was noted that the session was conducted through a translator who was not believed to be very reliable. Noted that from his interview, it appeared that the claimant did not want surgery, but he was uncertain due to translation issues. He noted that his pain drawing seemed inconsistent with a lumbar spine injury, but again there may be language difficulties in even completing the drawing. Stated that he should return for further evaluation with the presence of a professional translator and that no surgery should be planned until further evaluation was complete unless medically critical.

03/06/14: The claimant was re-evaluated. It was noted that he wished to avoid surgery. On exam, he had weakness at 4/5 in the left anterior tibialis and EHL with tension signs positive on the left leg only. He was referred for a chronic pain program.

06/13/14: The claimant was re-evaluated with complaints of low back pain, left leg pain and weakness, neck pain, and left arm pain and weakness. The reason for the visit was indicated as to discuss surgery. It was noted that he was in a chronic pain program with minimal improvement and wanted to consider lumbar surgery and surgical evaluation of the cervical spine also. He had noted continued weakness in the left arm and left leg. On exam, it was noted that his weakness was actually worse than previous at 3/5 in the left anterior tibialis and EHL and 4/5 in the left gastrosoleus. He had 5/5 strength in the right lower extremity. Tension signs positive on the left leg aggravating back pain and left leg pain. Tension signs positive on the right side aggravating bilateral back pain. An

MRI of the lumbar spine was recommended to assess for worsening nerve root compression on the deteriorating physical exam. It was noted that he had failure of conservative care including chronic pain program and oral pain medications.

06/19/14: UR. RATIONALE: There has been no significant clinical change, deterioration, or new trauma since the prior MRI. It is unclear why a different result might be expected; what suggests the presence of a structural abnormality not previously seen on MRI. There is insufficient information upon which to base a cogent determination of medical necessity. The medical necessity of this request is not certified.

06/26/14: UR D. RATIONALE: There was no report of a new acute injury or exacerbation of previous symptoms. There was no recent detailed physical examination of the lumbar spine provided for review. There was no mention that a surgical intervention is anticipated. There was no indication of decreased motor strength, increased reflex, or sensory deficits. There was no indication that plain radiographs were obtained prior to the request for more advanced MRI. There were no additional significant "red flags" identified. Given the clinical documentation submitted for my review, medical necessity of the request for the MRI of the lumbar spine without contrast has not been established.

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

The previous adverse decisions are overturned. The claimant has signs and symptoms of nerve root impingement at L4-L5 with L5 radiculopathy. If surgery is recommended (the office note dated 06/13/14 indicates that he presented for surgical discussion), the correct level of involvement needs to be determined, and MRI is indicated. The records indicate L5 nerve root involvement, but the diagnosis is L5-S1 disc herniation. L5 radiculopathy is typically a result of L4-L5 level disc problems. MRI would be useful in determining the levels involved. In addition, the claimant presented on 06/13/14 with worsened weakness on exam since previous MRI was obtained. He meets the ODG requirements of low back pain with radiculopathy after failed conservative therapy. Therefore, the request for MRI Lumbar without contrast is medically necessary.

**ODG:**

<p>MRIs (magnetic resonance imaging)</p>	<p><b><u>Indications for imaging -- Magnetic resonance imaging:</u></b></p> <ul style="list-style-type: none"> <li>- Thoracic spine trauma: with neurological deficit</li> <li>- Lumbar spine trauma: trauma, neurological deficit</li> <li>- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)</li> <li>- Uncomplicated low back pain, suspicion of cancer, infection, other "red flags"</li> <li>- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.</li> <li>- Uncomplicated low back pain, prior lumbar surgery</li> <li>- Uncomplicated low back pain, cauda equina syndrome</li> <li>- Myelopathy (neurological deficit related to the spinal cord), traumatic</li> <li>- Myelopathy, painful</li> <li>- Myelopathy, sudden onset</li> <li>- Myelopathy, stepwise progressive</li> <li>- Myelopathy, slowly progressive</li> </ul>
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	- Myelopathy, infectious disease patient - Myelopathy, oncology patient
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**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)**