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Notice of Independent Review Decision

February 12, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Lumbar Spine MRI w/o Contrast

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

The Reviewer is a Board Certified Orthopaedic Surgeon with over 42 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

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:

01/28/2013: Wrist x-ray
01/28/2013: Pelvis x-ray
01/28/2013: Shoulder x-ray
01/28/2013: Chest x-ray
01/28/2013: CT Spine Cervical
01/28/2013: CT Chest/ABD/Pelvis
01/28/2013: CT Brain/Head
01/29/2013: Testicular Ultrasound
01/29/2013: Cervical MRI
01/31/2013: L Spine MRI
01/31/2013: Thoracic Spine MRI
02/01/2013: Discharge Summary
02/07/2013: Evaluation

02/28/2013: Evaluation
06/18/2013: Progress Note
11/04/2013: Progress Notes
11/08/2013: UR
11/25/2013: Progress Note
12/12/2013: UR
12/16/2013: Progress Note
01/13/2014: Progress Note

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a male who was injured on xx/xx/xx. He was taken to the ER where a MRI revealed a L5 transverse process fracture along with a right paraspinous hematoma. He was hospitalized for 5 days and then referred to outpatient therapy.

01/28/2013: Wrist x-ray. Conclusion: Normal examination.

01/28/2013: Pelvis x-ray. Conclusion: There is no abnormality seen.

01/28/2013: Shoulder x-ray. Conclusion: Normal study.

01/28/2013: Chest x-ray.

01/28/2013: CT Spine Cervical. **Impression:** No cervical spine fractures.

01/28/2013: CT Chest/ABD/Pelvis interpreted. **Impression:** 1) A hematoma overlies the right paraspinous muscles measuring 9.3 x 2.6 cm transverse diameter. There is mild thickening of the right-sided posterior pararenal space measuring 4.6 x 1.3 cm transverse diameter consistent with a small hematoma. 2) There is a minimally displaced fracture of the right-sided transverse process of L5. 3) No solid or injuries. 4) A Foley catheter is present, with balloon tip filled within the bladder.

01/28/2013: CT Brain/Head interpreted. **Impression:** No acute intracranial pathology. Two metallic density foreign bodies (staples?) are present within the scalp overlying the right frontal bone.

01/29/2013: Testicular Ultrasound. Conclusion: Essentially normal examination.

01/29/2013: Cervical MRI. Conclusion: 1. There is no bone marrow edema to suggest a fracture or bone bruise. 2. There is no evidence of a cord injury or cord compression. There is no epidural hematoma. 3. There is a mild edema centered just to the left of midline in the interspinous space at T1-2 and T2-3, indicating a mild soft tissue/ligamentous injury. 4. There are mild degenerative changes. There is narrowing of most of the neural foramina, in some part due to congenitally short pedicles. 5. There is mild central stenosis at C4-5 through C6-7, primarily due to congenitally short pedicles.

01/31/2013: L Spine MRI. **Impression:** No acute abnormalities identified. Note chronic degenerative changes at the spine as above, with mild left-sided neural foramen stenosis at L5/S1 secondary to the described disc bulge/facet joint hypertrophy.

01/31/2013: Thoracic Spine MRI. **Impression:** No acute abnormalities identified at the thoracic spine. There is hypertrophy of the right-sided uncovertebral joint at C5/C6, causing right-sided neural foramen stenosis. Additional small broad-based posterior disc bulges are present without significant canal stenosis.

06/18/2013: Progress Note. **HPI:** Completed 12 sessions of physical therapy . Pain worse in lower and upper back and radiates to chest and shoulders. Constant pain rated 7-9/10. **Plan:** MRI bilateral shoulders. Referral Continue active therapy x 9 sessions.

11/04/2013: Progress Notes. **Medication List:** Amiodipine oral table 10mg, baclofen oral tablet 10mg, Lisinopril oral table 40mg, tramadol-acetaminophen oral tablet 37.5-5-325mg. **Assessment:** Sprains and strains of other and unspecified parts of back; thoracic, Lumbar Sprain. **Plan:** MRI-Lumbar spine w/out contrast.

11/08/2013: UR. Rational for Denial: The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. Per official disability guidelines, repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. There is no clinical documentation submitted which illustrates a significant change in symptoms. There is a lack of physical exam findings of the lumbar spine which would justify the need for an MRI. Per progress note dated 11/04/2013, there was no assessment of the lumbar spine noted. In addition, there was no submitted documentation elaborating on the amount of conservative therapy the patient completed. As such, the request for Repeat Lumbar Spine MRI w/o Contrast is not certified.

11/25/2013: Progress Note. **HPI:** He complains of pain in his cervical spine, thoracic spine, lumbar spine, right shoulder, and left shoulder. He complains of localized pain, pain with weight bearing, pain with motion, spasms, swelling, stiffness, and locking. The severity of his symptoms is moderate; the quality of pain is sharp, throbbing, stabbing, and burning. Symptoms have worsened. **Physical Examination:** Lumbar: Paraspinal musculature is nontender to palpation. Full Rom in all planes. Paraspinal muscle strength within normal limits. No muscle atrophy. Gait normal. Normal reflexes, and muscle strength in the lower extremities. **Assessment:** Sprains and strains of other and unspecified parts of back; thoracic, Lumbar Sprain, Sprains and strains of shoulder and upper arm; superior glenoid labrum lesion, Low back pain. **Plan: Orders:** Functional Capacity Evaluation, MRI-Lumbar spine w/o contrast.

12/12/2013: UR. Rational for Denial: An appeal request was made for a repeat lumbar MRI. The previous request was non-certified due to lack of documentation of clinical findings which illustrate a significant change in symptoms, no physical exam findings of the lumbar spine which would justify the need for an MRI, and no submitted documentation elaborating on the amount of conservative therapy the patient has completed. There is no indication that the patient's lumbar condition has worsened/progressed in order to warrant a repeat MRI. There is agreement with the previous determination and the medical necessity of this request is still not established at this point.

12/16/2013: Progress Note. **HPI:** Pt still having radicular pain with weakness to bilateral shoulders. MRI was denied for a 3rd time. He is presenting with the same symptoms as last time. **Physical Examination:** Lumbosacral spine: Tenderness to palpation lumbar paraspinal musculature. Limited ROM in all planes secondary to pain. Paraspinal muscle strength testing limited secondary to pain. Paraspinal muscle spasm and tightness. Negative straight leg raise bilaterally. **Assessment:** Sprains and strains of other and unspecified parts of back; thoracic. Lumbar Sprain. Thoracic Spine Pain. Lumbago. **Plan:** MRI- Lumbar spine w/o contrast.

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

The previous adverse determinations are upheld. After reviewing the provided medical records, repeated physical exams show no neurological deficits, motor function are intact, and SLR is negative. The first MRI was technically good, therefore, according to ODG guidelines, I see no indication for a repeat MRI. The request for Repeat Lumbar Spine MRI w/o Contrast is not recommended to be medically necessary.

PER ODG:

MRIs (magnetic resonance imaging)	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).
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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

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)**