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Notice of Independent Review Decision

**Date: December 17, 2013**

**IRO CASE #:**

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

Magnetic resonance (EG, Proton) Imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar

**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:**

- Office visits (07/29/13 – 11/15/13)
- Utilization reviews (10/22/13, 11/21/13)
- Utilization reviews (10/22/13, 11/21/13)

**ODG criteria have been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained injury to her low back on xx/xx/xx, when she experienced lower back pain.

**xxxx – 2009:** No records are available.

**2010:** Per utilization review dated March 29, 2010, the request for computerized tomography (CT) scan of the cervical spine was denied with the following rationale: *"The patient recently had a right total knee arthroplasty and postoperative physical therapy (PT). The patient had no objective findings on exam for cervical neurological deficits, cervical instability or acute cervical spine trauma. She had been taking medications (Soma and Lortab for many months). The patient was supposed to have a left total knee arthroplasty in a few weeks. stated the only reason he had for ordering the CT cervical scan was for the neurosurgeon or orthopedic specialist to have before the pending evaluation, which was not yet scheduled. stated he had not taken recent plain films of the cervical spine. The patient does not have any of the ODG criteria/indications to receive a CT of the cervical spine."*

Per utilization review dated July 31, 2010, the request for a repeat lumbar CT scan was denied as the clinical information provided did not establish the medical necessity of this request.

**2011:** No records are available.

**2012:** On November 15, 2012, the patient was evaluated for worsening lower back pain radiating to the left calf and left thigh, which she described as aching, numbing and sharp in nature. Her symptoms were aggravated by bending, standing and walking and relieved by pain medications. She also had bilateral hip pain and numbness. The patient also complained of moderate neck pain and stated that her right shoulder had been bothering her and she was not sure as to whether it was related to the neck. It had started about three days ago. Her other complaints include insomnia which was worsening and continual. Her chronic problems included bipolar I disorder, single manic episode, and unspecified idiopathic peripheral neuropathy. Her ongoing medications included Cymbalta, fentanyl patch, levothyroxine, Lortab, Soma, Synthroid and Xanax. Examination of the lumbar spine revealed tenderness in the sacroiliac (SI) joints bilaterally with painful movement in the area. diagnosed symptomatic chronic pain, unspecified symptomatic idiopathic peripheral neuropathy, and symptomatic sciatica due to displacement of lumbar disc. He stated that the new symptoms were worse and the patient would benefit from a magnetic resonance imaging (MRI) of the lumbar spine to evaluate any misalignment. She needed to continue her pain medications and would need treatment for the rest of her life.

On November 29, 2012, ordered an MRI of the lumbar spine.

On December 4, 2012, tried to have a telephonic consult but had to leave his message on the automatic answering machine. He noted the summary history as follows: *"The patient was a female with a date of injury reported as xx/xx/xx. The patient has a surgical history of cervical fusion x3 with hardware (1997), L4-L5 laminectomy (2000), left knee arthroscopy (2009) and right knee arthroscopy (2010). There was no documentation indicating how the patient got injured. A CT scan (2007) revealed no new herniations of the lumbar spine. The CT of the lumbar spine completed on April 9, 2009, revealed postoperative change of L4-L5*

*laminectomy, posterior fusion at L4 through S1 and fusion posterior rod fixation on the left from L4 through S1, on the right at L5-S1. There were no areas of canal stenosis specified. A small vertebral body hemangioma was incidentally noted within the left side of L2. A progress note dated May 4, 2012, noted that she had increased pain especially on the left with walking. She complained of pain in her neck and back and was prescribed Lortab, Soma, Xanax and Cymbalta. On February 22, 2012 a caudal lumbar steroid ESI was denied per chart review.*

*On August 14, 2012, the follow-up revealed the patient wanted more testing for LBP with radiation into the left lower extremity. The patient is taking/utilizing Fentanyl patches, Soma, Xanax and Cymbalta. She had chronic pain, bipolar I disorder, and idiopathic peripheral neuropathy. On October 12, 2012, the follow-up exam revealed lumbar ROMs with severe pain. The plan was to continue medications and return to the clinic in three months."*

denied the request for the MRI of the lumbar spine with the following rationale: *"The above clinical summary findings support the diagnosis of a chronic lumbar pain disorder. The signs and symptoms have basically stayed the same for a number of years without any progressive signs and symptoms (neurologic deficits, etc). The exam of November 15, 2012, revealed that the motor/sensory findings were normal. could not be reached to discuss this case or to provide more medical support/necessity for the requested lumbar MRI study and the request did meet the ODG/low back MRI guidelines. The date of injury was xxxx. The claimant has a very remote history of an L4-S1 fusion. An objective for clinical findings did not show neurological, motor or sensory deficits and therefore the request was denied.*

**2013:** On July 29, 2013, examined the patient for persistent back pain that was worsening. On examination, the patient's left foot/ankle showed less feeling. The left ankle reflexes were absent and there were depressive symptoms for the worsening pain. diagnosed worsening sciatica due to displacement of lumbar disc and dysthymic disorder, worsening chronic pain, symptomatic peripheral neuropathy and worsening dysthymic disorder. He added Ambien and continued the previously prescribed medications.

On September 9, 2013, the patient reported that Workers' Compensation needed a letter to send to approve her Soma, Celexa, Abilify and Savella. She had tried Flexeril and Robaxin with no benefit. Abilify and Savella had helped her moderate-to-severe mood changes and crying related to intense chronic pain and peripheral neuropathy effects like inability to perform activities of daily living (ADLs) and go to store for necessity. requested appealing for the medication denials and scheduled her for a follow-up in one month. He also referred her to a neurosurgeon for neurosurgical evaluation.

Per utilization review dated October 22, 2013, the request for MRI of the lumbar spine (with and without contrast) was denied with the following rationale: *"The MRI of the lumbar spine (with and without contrast) is not medically necessary and appropriate. The patient's back surgery occurred xx years ago. The patient*

*had an absent left Achilles DTR in July 2013, but this was not documented again, nor is it clear if this is a new or chronic finding. The work-up and treatment post fusion is not delineated either. Unless it is known that the patient is having a new or evolving radiculopathy, the MRI is not supported."*

On November 8, 2013, evaluated the patient for worsening back pain. He continued her on medications and commented that the loss of reflexes reflecting worsening of her nerve injury were the new findings of worsening. She still needed evaluation of this and needed her pain medications since there was so far no improvement in her pain but only worsening. By this the patient needed to seek legal help for her denied appropriate medical care. He scheduled her for a follow-up in three months.

Per utilization review dated November 21, 2013, the reconsideration was denied a neurosurgeon, with the following rationale: *"The claimant on xx/xx/xx, experienced lower back pain. The claimant has history of chronic back pain, status post L5 hardware and cervical surgeries x3 with hardware placement. Currently the findings from the documents do not show any neurological compromise or any significant changes that would warrant an MRI, therefore sending for peer review. Guidelines: ODG/Low back/MRI- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The MRI of the lumbar spine (with and without contrast) is not medically necessary. According to the ODG "Low Back" chapter, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)." The provider, in his note of November 8, 2013, states that there is a loss of reflexes but no examination is provided for review. The last neurological examination is from November 15, 2012. Therefore, medical necessity for a repeat MRI is not established by the documentation submitted for review and therefore is not medically necessary."*

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

The patient is lady who had a work injury on xx/xx/xx, when she experienced low back pain. There were no records from xxxx to 2009 for review.

The records of 2010 include a request for a cervical spine MRI on March 29, 2010. It is noted there that the patient had had a prior right total knee arthroplasty and postoperative physical therapy and that the CT scan was being ordered a prelude to patient being evaluated by a neurosurgeon or an orthopedic specialist. on the preauthorization peer to peer apparently had stated he had not taken recent films of the cervical spine. The request was denied as a medical necessity.

The next records are from November 15, 2012, when evaluated the patient for worsening low back pain with radiation to the left calf and left thigh. The patient also was complaining of some bilateral hip pain and numbness. She was also

having neck pain that radiated towards the right shoulder. She also had multiple psychological/psychiatric issues. Her medications included Cymbalta, fentanyl patch, levothyroxine, Lortab, Soma and Xanax.

The lumbosacral spine exam showed tenderness into the SI joints. However, the neurological exam showed no motor deficits, her gait was normal and there were no reflex abnormalities noted. She did have hypoesthesia in a stocking distribution in the lower extremities. Her BMI was 37.93. ordered a new MRI as of November 25, 2012.

Pre-certification review on December 4, 2012, noted her clinical history and surgical history. He noted a prior CT scan of the lumbar spine completed in 2007 showing no new herniations of the lumbar spine and then also one completed on April 9, 2009, showing the postoperative changes of the L4-L5 laminectomy and posterior fusion from L4 through S1. There was instrumentation on the left from L4 through S1 and on the right at L5-S1.

The request was denied as determined that the request did not meet ODG criteria. There was no objective neurological change or deficits. The date of injury was noted to be in xxxx.

On July 29, 2013, re-examined the patient. Now the patient was reported to have less feeling in the left foot and ankle but also the left ankle reflex was absent. The patient was also noted increasing depression symptoms. reported worsening sciatica due to possible disc displacement as well as symptomatic peripheral neuropathy. (Reviewer's Comment: The left ankle reflex would be an S1 related innervation or muscle stretch reflex and this is the spine area where there was the previous fusion.)

On September 9, 2013, the patient requested a letter of support for her medications to include the Soma, Celexa, Abilify and Savella. The other muscle relaxants, i.e., Flexeril and Robaxin had been tried apparently without benefit. The Abilify and Savella were helpful for her mood changes due to the intense chronic pain. He proposed a referral to a neurosurgeon for evaluation.

The request for the MRI of the lumbar spine was assessed on pre-cert review an anesthesiologist, who noted that the patient had the absent left Achilles reflex reported in July 2013 but that the reflex abnormality had not been documented subsequently. Thus, the request was not considered to represent a medical necessity.

On November 8, 2013, stated that the patient was going to need to proceed with legal help in her quest for further diagnostics. However, there was no new neurological assessment performed or reported at least.

On November 21, 2013, a neurosurgeon, performed a pre-certification review for the repeat MRI. He noted that the ODG would not support this request as there was no neurological compromise or significant changes that would warrant this

MRI. He noted as well that the neurological examination subsequent to November 15, 2012, were absent.

Reviewer's comment: It was noted that the denials for the MRI were addressed although there were no records from for review.

In summary, then, this patient has had a previous L4 to S1 fusion performed for the apparent xxx work incident or its residuals. However, the examination findings that are reported do not define a new objective neurological deficit that would warrant a repeat imaging study. Moreover, an MRI with previous instrumentation present is likely to give a suboptimal exam, especially at the L4 to S1 levels. The S1 level had the alleged new ankle jerk reflex change. This level would be poorly analyzed on an MRI with or without contrast due to shadowing associated with hardware present.

Thus the request does not appear to meet medical necessity requirements due to unsubstantiated new neurological change on a recurrent basis. Please note that there were no measurements of atrophy of the lower extremities. Moreover, the neurological exam of November 15, 2012, was considered to be essentially normal.

Moreover, technically the MRI request would provide a suboptimal analysis of the anatomy at L4-L5 and L5-S1 and thus would not be medically necessary based on just technical factors as well. However, the major issue here is that it does not meet medical necessity because the neurological does not substantiate this necessity.

**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-DWC Low Back