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Notice of Independent Review Decision

July 2, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar MRI with and without contrast

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Physical Medicine and Rehabilitation Physician

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.

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:

- Office visits (01/23/13 - 02/04/14)
- Telephonic notes (04/11/14 - 04/21/14)
- Utilization reviews (04/29/14, 05/27/14)

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PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who was injured on xx/xx/xx.

2012: On December 10, 2012, evaluated the patient for follow up on right L5 and S1 transforaminal epidural steroid injection (TESI). The patient reported improvement in his daily activity and reduction in his overall pain with medication use. He was able to complete activities of daily living without any assistance. His pain was 5/10 with medications. He got about 40% relief. The patient still complained of coccyx pain and numbness in the right anterior thigh. The coccyx pain was worse with bowel movements, standing and sitting. His history was remarkable for a bulging lumbar disc with pain in the lower right lumbar spine radiating to right buttocks, right hips, right anterior and posterior thigh, right entire lower leg and tailbone. The pain was mild-to-moderate, sharp, throbbing, aching, burning, cramping and stabbing. He had associated stiffness, paravertebral muscle spasm, radicular right leg pain, numbness in the right anterior and posterior thigh and right entire lower leg and weakness of the right upper leg and right lower leg. The pain worsened with walking, sitting, laying and standing. He had a history of back surgery and underwent conservative therapies to include narcotics and neuropathic medications with relief. His review of systems was positive for severe fatigue, arthralgias, chronic back pain, right leg pain, myalgias, right lower extremity paresthesias, right lower extremity weakness, easy bruising, hair loss and hypersomnia. He had a history of left ankle fracture repair in 1992, lumbar fusion in 2006, cerebrovascular accident and hypertension. He was utilizing Lortab, Neurontin, lisinopril and Plavix. On examination, his gait was affected by a limp. Ms. diagnosed bulging lumbar disc and performed intrathecal pump re-programming with Bupivacaine 20 mg/ml and 10.0 mg/ml of Astramorph. The re-programming was run at a rate of 4.209 mg/ml per day. The patient was observed for 30 minutes. The pump was increased by 3%. Ms. recommended x-ray of the lumbosacral/coccyxgeal area to rule out fracture.

2013: On January 23, 2013, noted severe pain in the tailbone, right lower leg and increased weakness and numbness in the lower extremities. The patient had pain over the coccyx on examination. There was limited range of motion (ROM) with lumbar extension and flexion. Sensory deficit was noted in the right L3, right L4 and right L5 distribution. There was positive bilateral straight leg raise (SLR) for back pain and positive bilateral slump for back pain. diagnosed bulging lumbar disc and essential hypertension. The patient was recommended caudal epidural steroid injection (ESI) and ordered new magnetic resonance imaging (MRI) of the lumbosacral spine with and without contrast. The patient had urinary retention and was to see his primary care physician (PCP). The gabapentin dose was increased to 600 mg b.i.d. for two weeks followed by t.i.d. He was also having trouble sleeping and was offered reclining lift chair.

On August 20, 2013, evaluated the patient for synchromed pump program. Examination revealed gait affected by a limp. diagnosed bulging lumbar disc, lumbar spondylarthritis, chronic pain syndrome and essential hypertension. performed intrathecal pump re-programming with morphine 20 mg/ml and Bupivacaine 30 mg/ml and was programmed to run at rate of 4.497 mg per day. The patient was observed for 30 minutes. The pump was increased by 2%.

On September 3, 2013, evaluated the patient for synchromed pump refill program. The patient rated his pain at 6/10. performed intrathecal pump re-programming with morphine 20 mg/ml and Bupivacaine 30 mg/ml and was programmed to run at rate of 4.584 mg per day. The patient was observed for 30 minutes. The pump was increased by 2%.

On September 9, 2013, evaluated the patient for synchromed pump refill and program. performed intrathecal pump re-programming with morphine 20 mg/ml and Bupivacaine 30 mg/ml and was programmed to run at rate of 4.584 mg per day. The patient was observed for 30 minutes.

2014: On February 4, 2014, evaluated the patient for pump refill and re-program. The patient rated his pain at 7/10. The patient reported lumbar back pain radiating to the right lower leg, right shin and right foot. The pain was sharp, dull, aching and burning. It was described as moderate-to-severe. It was precipitated by a fall. The pain was exacerbated by weightbearing, back motion, standing, sitting, prolonged standing, prolonged sitting, lifting, bending and walking. It was relieved by rest and opioid analgesics. The associated symptoms included leg numbness and leg weakness. The patient was utilizing gabapentin, hydrocodone-acetaminophen, Zegerid, Plavix and lisinopril. On examination, the patient had a normal posture and normal gait and station. diagnosed chronic pain syndrome, essential hypertension and lumbosacral radiculopathy. performed intrathecal pump re-programming with morphine 20 mg/ml and Bupivacaine 30 mg/ml and was programmed to run at rate of 5.098 mg per day. The patient was observed for 30 minutes. The pump was increased by 5%. It was noted that the patient was having a knee replacement in two weeks.

Per a telephonic note dated April 11, 2014, the patient's wife called and reported that the patient was attending physical therapy (PT). He started complaining of leg pain and was told it was related to his back. The wife wanted to know whether could see the patient for his bone nerve stimulator that was placed in 2006. wanted to know what type of stimulator it was and recommended thoracic and lumbar x-rays after approval from workers compensation (W/C).

Per a telephonic note dated April 17, 2014, the adjuster was called who reported that the patient had EBI Spinal Fusion Stimulator on Q subcutaneous marcine infusion catheter placement on October 3, 2006. The patient had a root decompression at bilateral L5-S1, bilateral L5-S1 interbody technique, bilateral L5-S1 interbody cage implants, bilateral L5-S1 pedicle screws and plates, morselized auto graft. These were W/C related.

Per a telephonic note dated April 21, 2014, the adjuster stated that the stimulator was a bone stimulator and so he should be ok to get a lumbar spine MRI for the leg radiculopathy. Approval was sent. The patient's wife was informed that the patient could have an MRI with and without contrast and approval from W/C was placed.

Per utilization review dated April 29, 2014, the request for repeat MRI of lumbar spine with and without contrast was denied with the following rationale: *"The patient is a male who sustained an injury on xx/xx/xx. He is diagnosed with chronic pain syndrome, essential hypertension and lumbosacral radiculopathy. A request is made for repeat MRI of the lumbar spine with and without contrast. The patient complained of pain in his lumbar spine area. He was treated conservatively with PT and epidural injections but the patient's symptoms persisted. He eventually underwent a posterolateral fusion of the L5-S1 on October 3, 2006. Postoperatively, he was treated with physical therapy (PT). The patient is reported to have been deemed at maximum medical improvement (MMI) on October 15, 2007 and assigned a 5% impairment rating. A DDE dated December 17, 2007 is included in the submitted medical records. The patient was noted to have continued pain in the low back. He was reportedly scheduled to have morphine pump implanted on December 18, 2007. also assigned a 5% WPI rating to the patient. An operative note dated December 30, 2010 indicates that the patient had removal of the intrathecal narcotic infusion pump and replacement of a new catheter and intrathecal pump. MRI of the lumbar spine was done on February 25, 2011 and revealed status post posterior L5-S1 spinal fusion with intact orthopedic hardware. The intervertebral disc spacer was in satisfactory position. There was note of mild central disc protrusion with associated epidural fibrosis at the L5-S1 level possibly involving the exiting right S1 nerve root. Mild focal arachnoiditis at L3 was noted. There was also note of minimal multilevel degenerative changes. Electrodiagnostic studies of the lower extremities done on May 10, 2011 revealed no electrical evidence of peripheral neuropathy, entrapment neuropathy, radiculopathy or other neuromuscular disease. Subsequent medical records indicate that the patient was on follow up who treated the patient's continued low back pain with medications. Reprogramming of the patient's intrathecal pump was also done. The patient was seen on February 4, 2014 for pump re-programming and/or refill. He continued to complain of pain at a level of 7/10. The pain radiated to the right leg. Physical examination showed normal findings. The patient is noted to undergo knee replacement in two weeks. His intrathecal pump was refilled and increased by 5%. A note dated April 11, 2014 indicates that the patient's wife called the provider's office and stated that the patient has been attending PT and started complaining of leg pain. It was also stated that the patient had a bone and nerve stimulator placed when he had his lumbar fusion in 2006. wanted to get details regarding the stimulator and recommended a thoracic and lumbar x-ray for evaluation. A note dated April 21, 2014 stated that the patient's stimulator was a bone stimulator and he should be okay to get a lumbar MRI for the leg radiculopathy. A request was made for lumbar MRI with and without radiculopathy. Regarding the request for repeat MRI of the lumbar spine, the patient is noted to have undergone lumbar fusion in 2006 and intrathecal pump implantation in 2010. A previous MRI dated February 25, 2011 revealed intact fusion orthopedic hardware and intervertebral disc spacer in satisfactory position. There was also note of mild central disc protrusion with associated epidural fibrosis at the L5-S1 level possibly involving the exiting right S1 nerve root. Subsequent records indicate that the patient was being managed with the intrathecal pump, medications aid therapy. The most recent record with clinical*

information is an encounter note dated February 4, 2014 when the patient was seen for reprogramming of his pump. Referenced guidelines indicate that repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. There was no indication of significant change in the patient's symptomatology as of the February 4, 2014 encounter note. Physical exam findings at that time were normal. The subsequent note dated April 21, 2014 only stated that lumbar MRI is requested for the patient's leg radiculopathy. There were no objective findings indicative of significant pathology that would warrant repeat MRI. Elaboration on the patient's progress and treatment since the February 4, 2014 follow-up may be needed. The medical necessity of the requested repeat MRI of the lumbar spine with and without contrast is not fully substantiated at this time. During telephonic contact, a message was left that informed the provider's office the case will be non-certified without additional information."

Per reconsideration review dated May 27, 2014, the appeal request for repeat MRI of lumbar spine with and without contrast was denied the following rationale: *"The patient is a male who sustained an injury on xx/xx/xx. He is currently diagnosed with chronic pain syndrome, essential hypertension and lumbosacral radiculopathy. An appeal request was made for repeal lumbar MRI. The previous request was non-certified because there was no indication of significant change in the patient's symptomatology and there were no objective findings indicative of significant pathology that would warrant the repeat MRI. Documentation submitted for this appeal includes telephone notes from April 2014, various evaluation reports from 2011 to 2013 and the February 25, 2011 lumbar MRI report. The patient has been experiencing chronic low back pain with associated lower extremity symptoms. His treatment history is significant for surgical procedures, namely posterolateral L5-S1 fusion on October 3, 2006 and pump placement on an unspecified date with subsequent removal and pump replacement on December 30, 2010. Other treatments rendered in the past have included medications, PT, ESIs, and home exercises. Despite these interventions, he remained persistently symptomatic. An updated lumbar MRI was obtained on February 25, 2011 and was read to have shown fusion changes at L5-S1 with associated mild disc protrusion and epidural, fibrosis along the thecal sac, possibly involving the exiting right S1 nerve root. Mild focal arachnoiditis at L3 and minimal multilevel degenerative changes were also seen. EMG/NCV of the lower extremities on May 10, 2011 revealed no electrical evidence of peripheral neuropathy, entrapment neuropathy, radiculopathy, or other neuromuscular disease. Right L5-S1 ESI was reported to have been more recently performed on July 16, 2012 and November 26, 2012. On February 4, 2014, the patient presented for follow-up to reprogram and/or refill 1% pump. He continued to present during this visit with low back pain radiating to his right lower extremity with associated leg numbness and weakness. He was noted to be taking gabapentin, hydrocodone-acetaminophen, Zegerid, Plavix and Lisinopril. On physical examination, the patient was observed to have a slow and limping gait. Other reported findings were within normal limits. The intrathecal pump was refilled and increased by 5%. In the April 11, 2014 telephone note, it was stated that the patient's wife called to report that he had been attending PT. He*

reportedly started complaining of leg pain and was told that it was related to his back, it was mentioned that he had a bone and nerve stimulator placed when he had his lumbar fusion in 2006. reportedly wondered what type of stimulator this is, and thus advised the patient to obtain thoracic and lumbar x-rays for evaluation. In the subsequent note dated April 21, 2014, it was stated that the stimulator is a bone stimulator. It was further noted that the patient "should be okay" to get a lumbar MRI for his leg radiculopathy. The records submitted for his appeal still did not address the issues raised in the previous determination. There were still no reported objective findings indicative of a significant change in the patient's symptomatology, particularly since he last had MRI in 2011. An updated physical examination which documents neurologic deficits suggestive of progressive and/or new lumbar spine pathologies was also still not delineated in the latest records provided to justify the need for repeat MRI investigation at this juncture. An agreement with the previous determination, the medical necessity of this request is not substantiated."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The basis for the repeat MRI of the lumbar spine appears to be secondary to subjective complaints of increased pain, no objective deterioration in functional status or exam findings are appreciated in the available documentation for review to support the requested repeat MRI. Treatment notes since the requested MRI of the lumbar spine do not describe acute deterioration in neurological or musculoskeletal exam findings to support the request.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**