

**Maturus Software Technologies Corporation**

**DBA Matutech, Inc**

881 Rock Street  
New Braunfels, TX 78130  
Phone: 800-929-9078  
Fax: 800-570-9544

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Notice of Independent Review Decision

**October 20, 2014**

**IRO CASE #:**

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

Lumbar MRI with and without contrast (72158)

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

Certified by the American Board of Orthopaedic Surgery  
Recertified by the American Board of Orthopaedic Surgery, 2011  
Orthopaedic Sports Medicine Subspecialty CAQ, ABOS, 2011

**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.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is female who injured her left shoulder, right knee and low back.

On June 15, 2012, magnetic resonance imaging (MRI) of the lumbar spine identified: (1) at L5-S1, disc protrusion/early herniation in the paracentral location with L5 nerve root compression bilaterally, right > left, particularly on the right side due to significant degenerative hypertrophy of the facet joint, with abutment of the S1 nerve root sleeve. (2) at L4-L5, broad-based diffuse bulging disc annulus with moderate facet arthropathy and ligamentum flavum hypertrophy contributing to mild central canal stenosis and moderate biforaminal narrowing, with abutment of the exiting L4 nerve roots bilaterally, particularly on the right (3) There was no acute compression fracture. (4) There was minimum degree of levoscoliosis.

On January 28, 2013, performed bilateral laminectomy, discectomy, and dural grafting using amniotic shield at L5-S1. The postoperative diagnosis was herniated nucleus pulposus (HNP) L5-S1.

On the same date, the patient was also seen, who assessed acute hypercapnic respiratory failure, obstructive hypoventilation, postoperative respiratory insufficiency, respiratory depression secondary to medication use, severe obstructive sleep apnea by history and history of tobacco use and asthma. noted the patient was tolerating bilevel positive airway pressure (BiPAP) therapy. He increased BiPAP setting and discouraged IV narcotic administration.

On May 15, 2013, over three months after surgery, saw the patient for back pain and leg pain located on the left side. Pain in the back radiated down her leg. Examination revealed radiculopathy, positive SLR on the right and tenderness over the lumbar spine with slight decreased sensation on the left side in the L5 dermatome. noted the patient was doing well with physical therapy (PT). However, the patient stated that her pain had come back as before. prescribed Celebrex and Medrol Dosepak and ordered MRI of the lumbar spine.

On May 31, 2013, MRI of the lumbar spine identified: (1) Status post L5-S1 laminectomy and discectomy. (2) Paracentral disc protrusion abutting the S1 nerve root bilaterally and slightly to the right, as well as a bulging disc causing compression of the L5 nerve root bilaterally, particularly on the right, with some posterior displacement of the nerve root presumable on the basis of radiculitis. (3) Postsurgical changes were noted at the L5-S1 level, which showed no marked degree of enhancement after infusion of the contrast material indicating no significant degree of postsurgical granulation tissue at the L5-S1 level. (5) There was no acute compression fracture. (6) There was no disc extrusion.

The patient had follow-ups on June 20, 2013 and August 21, 2013, for complaints of low back pain and left leg pain. The patient was maintained on Celebrex, Zanaflex, Klonopin and trazodone. Lumbar epidural steroid injection (ESI) was recommended.

On October 22, 2013, performed a designated doctor evaluation (DDE) and opined that the patient had reached maximum medical improvement (MMI) as of August 23, 2012. The report is incomplete.

On November 21, 2013, performed lumbar transforaminal ESI.

On November 21, 2013, noted the patient was still having some stiffness and pain in the low back. She reported that the injection did not help her. recommended to hold off on recommendation for revision surgery. He recommended trying to get back to work with restrictions.

**2014:** On January 9, 2014, noted that the patient was very frustrated with the pain and wanted to go ahead with the surgery. Examination revealed 4/5 strength

testing with dorsiflexion and decreased sensation in the L5 dermatomes. There was pain and tenderness right over the L5-S1 segment. recommended anterior lumbar fusion at L5-S1.

On April 2, 2014, the patient underwent a functional capacity evaluation (FCE) and demonstrated ability to perform at light physical demand level (PDL). The evaluator recommended interdisciplinary rehabilitation program.

On the same day, the patient was seen who assessed status post work related injury, status post lumbar surgery with chronic pain, failed conservative treatment postop. recommended interdisciplinary rehab program for functional restoration.

The patient also underwent a behavioral health assessment and was diagnosed with pain disorder associated with both psychological factors and a general medical condition. The evaluator opined that the patient was an appropriate candidate for an interdisciplinary rehabilitation program.

On May 21, 2014, recommended chronic pain management program (CPMP).

Per discharge summary dated July 10, 2014, the patient had completed pain management treatment on July 1, 2014. The patient believed that she had benefited from the program.

On July 16, 2014, noted the patient was very frustrated with the pain. The pain had slowly been worsening for her. She had a procedure in which she had a laminectomy/discectomy done which she stated helped the leg pain but she was still left with significant back pain. recommended obtaining MRI in order to evaluate further.

Per utilization review dated July 31, 2014, the request for repeat MRI of the lumbar spine with and without contrast was denied with the following rationale: *"The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The patient is as female who reported an injury on xx/xx/xx. The mechanism of injury was a motor vehicle accident. Her diagnoses included lumbar intervertebral disc without myelopathy. Current medications were noted to include Medrol Dosepak, 4 mg tablets as directed; Zanaflex 4 mg tablets, 1 at bedtime; Klonopin tablets; and trazodone HCl. The doses and frequencies were not provided within the documentation available for review. Prior surgical history was noted to include back surgery on January 28, 2013. Diagnostic studies included an unofficial MRI of the lumbar spine dated May 31, 2013, which was noted to reveal status post L5-S1 laminectomy and discectomy. In addition, there was a paracentral disc protrusion abutting the S1 nerve root bilaterally and slightly to the right, as well as a bulging disc causing compression of the L5 nerve root bilaterally, particularly on the right; with some posterior displacement of the nerve root presumably on the basis of radiculitis. Other therapies were noted to include epidural steroid injections and physical therapy. The clinical note dated July 16, 2014, indicated that the patient presented with slowly worsening low back pain. She stated her lumbar surgery*

*had helped her leg pain, but she continues to have significant back pain. Her physical examination revealed mild motor strength deficits to 4/5 in dorsiflexion bilaterally and decreased sensation in an L5 distribution. The Official Disability 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. The clinical documentation provided for review indicates the injured worker has mild neurological deficits in an L5 distribution. However, there was not sufficient evidence submitted to establish a significant change in condition or progressive neurological dysfunction as the patient was noted to have low back pain, but no current significant lower extremity symptoms were noted. Therefore, the request for a repeat MRI of the lumbar spine is non-certified.”*

Per reconsideration review dated August 25, 2014, the request for MRI of the lumbar spine with and without contrast was denied with the following rationale: *“The Official Disability Guidelines state that indications for imaging of the lumbar spine include: thoracic spine trauma with neurological deficit, lumbar spine trauma with neurological deficit or a seat belt fracture if there are focal radicular findings or other neurological deficits, uncomplicated low back pain with the suspicion of cancer, infection, or other red flags, uncomplicated low back pain with radiculopathy after at least 1 month of conservative therapy (sooner if severe or progressive neurological deficits), uncomplicated low back pain prior to lumbar surgery, or with cauda equina syndrome, and myelopathy that is traumatic, painful, sudden onset, step-wise progressive, slowly progressive, or myelopathy in an infectious disease or oncology patient. Based on the clinical information submitted for review the patient had undergone an MRI of the lumbar spine on May 31, 2013. The most recent document provided dated July 16, 2014, did not show a physical examination to determine the presence of any significant changes and symptoms that would indicate the need for an additional MRI. Without information regarding clinical examination findings to determine a significant change in symptoms since the last MRI, an additional MRI would not be supported. As such, the request is non-certified.”*

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

The denial of the requests for a repeat postoperative lumbar MRI (2<sup>nd</sup> postoperative study) appears to be appropriate and consistent with ODG criteria. There is insufficient objective evidence of a progressive neurologic deficit that would warrant another postoperative lumbar MRI.

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

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