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Notice of Independent Review Decision

August 27, 2014

IRO CASE #:

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certification: American Board of Orthopaedic 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.

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female who developed low back pain when she bent down to pick up a container, twisted and turned on xx/xx/xx.

PRE-INJURY RECORDS

On February 25, 2003, a computerized tomography (CT) of lumbar spine without contrast showed at L4-L5, posterior extension of the contrast and a few bubbles of air consistent with torn annulus. The posterior displacement of contrast at this level was best seen on the sagittal reconstruction.

On April 22, 2003, evaluated the patient for complaints of low back pain. The patient stated she had this pain since 11 years. The pain increased with bending forward, quick back motions, walking and prolonged sitting. Frequent position changes and massage therapy decreased her pain. Over-the-counter (OTC)

medications had helped her back pain to some extent. She had an annular tear at L4-L5 and her lumbar discogram revealed concordant low back pain at L4-L5. She had failed conservative treatment and wished to proceed with selective endoscopic discectomy with annuloplasty. She was utilizing Tylenol, Imitrex, hormone replacement and Lasix.

POST-INJURY RECORDS

2004: On October 22, 2004, a magnetic resonance imaging (MRI) of the lumbar spine was performed due to low back pain. It was noted that the patient had a previous lower back surgery one-and-a-half year ago and had sustained a recent injury. The MRI showed mild postsurgical changes at the L4-L5 disc level and in left L4-L5 neural foramen. There was no focal posterior disc bulge or evidence of recurrent disc herniation. There was mild degenerative change at L4-L5 disc along with mild annulus bulge. There was mild narrowing of inferior portions of L4-L5 neural foramina. There was no central canal stenosis, compression deformity or bone marrow infiltration.

2005: On October 13, 2005, an MRI of the lumbar spine with and without contrast showed moderate spinal canal and left greater than right neural foraminal stenosis at L4-L5 secondary to a 4-mm disc osteophyte complex with associated endplate degenerative changes.

2006: On February 23, 2006, x-rays of the lumbar spine, two views, were performed while performing laminectomy fusion in the operating room. Two fluoroscopic spot films were noted. One noted the insertion of the pedicle screws and rods in the L4-L5 level bilaterally and the other noted normal alignment and positioning of the visualized lower lumbar spine.

From July 17, 2006, through December 13, 2006, the patient was under the care of who diagnosed her with lumbago, lumbar internal disc derangement, grade I spondylolisthesis and L4-L5 disc protrusion. The patient was status post laminectomy fusion and was doing quite well with her TLSO brace and bone stimulator. She was doing her daily home physical therapy (PT) and was utilizing Relafen, Flexeril and Lyrica. She had completed PT and was off her TLSO brace. X-rays performed on August 11, 2006, showed hardware to be in excellent location and intact. There was complete fusion along the lateral gutters noted and intervertebral spaces. The bony structures were unremarkable. recommended a functional capacity evaluation (FCE) and scheduled the patient for a second opinion regarding her medical improvement. Relafen and Lortab were prescribed.

2007: From January 10, 2007, through December 21, 2007, the patient continued to be under the care for ongoing lumbar spine issues. The patient was overall doing well. The patient underwent FCE and received 20% whole person impairment (WPI) rating. She had x-rays of the lumbar spine performed on September 24, 2007, that showed hardware to be in excellent location as well as intervertebral cage. There was great callus formation along the left lateral gutter and she had complete fusion on the right as well. She was continued with

conservative medical treatment with PT and medications to include Lyrica and Relafen. In mid-October, the patient had a falling incident at home landing on her left side that resulted in some severe pain over her left shoulder and side. It was noted that somehow the pain along the left lumbar sacral region subsided after the fall. discussed potential changes of long-term medication use.

2008: From March 20, 2008, through December 17, 2008, the patient continued care. The patient did well with exercises on a regular basis. It was noted that in January 2008, she had an upper respiratory infection causing a flare-up in her lower lumbar pain, but it subsided eventually. She was utilizing Relafen, Soma and Lyrica. recommended continuing medications and avoiding exacerbating factors. In xx/xxxx, the patient reported an accident at home slipping and falling in the bathroom and landing on her right side. This caused immediate pain along the right lumbosacral region. She also reported another fall when she tripped and landed on her left side resulting in 8/10 pain. Lumbar x-rays were done on November 5, 2008, that revealed hardware to be in excellent location along with intervertebral cage. The osteoblastic activity was asymmetrical on the lateral gutters, left greater than right. recommended proceeding with a CT of the lumbar spine and prescribed Lidoderm patch. Subsequently, the patient had a lumbar CT performed on December 4, 2008, that revealed a solid anterior and posterior fusion at L4-L5, some facet arthrosis at L3-L4 with some spinal canal stenosis and mild facet arthrosis at L5-S1. diagnosed lumbago and lumbar radiculopathy and recommended lumbar MRI to evaluate the low back and radicular symptoms. wanted to make sure that she did not have any herniated disc.

2009: On January 26, 2009, an MRI of the lumbar spine showed laminectomy and fusion at L4-L5 with epidural fibrosis in the lateral recess on the left. There was some tilt to the fusion graft, but no foraminal impingement was seen. The hardware appeared in good position and was intact.

From March 27, 2009, through August 11, 2009, the patient was seen for ongoing low back complaints. The patient reported right-sided sacroiliac (SI) pain and midline low back pain especially on the right. There was occasional right lateral thigh pain. Sitting for prolonged periods would increase the pain. reviewed the MRI dated January 26, 2009, and diagnosed lumbago and right sacroiliitis. had recommended bilateral L3-L4 facet blocks and SI joint injections, but was not approved by the insurance company. X-rays of the lumbar spine performed on August 11, 2009, showed laminectomy of L4-L5 with pedicle screws at the same level and cage at L4-L5. The plan was to continue Soma, Relafen and Lyrica; using proper body mechanics, applying ice and heat and stretching exercises.

On August 11, 2009, an MRI of the lumbar spine showed laminectomy and fusion with rod and pedicle screw fixation at L4-L5. There was wide patency to the canal and foramina at the operated level. Incorporation of the graft at the upper endplates of L5 was not well demonstrated.

On September 9, 2009, reviewed the lumbar MRI and recommended getting a CT scan to rule out bone spur growth on the lateral side of L4-L5. The patient was

also recommended a left L4-L5 transforaminal epidural injection to relieve the pain. continued Lyrica, Soma and exercises.

On October 1, 2009, performed right L5-S1 transforaminal epidural injection with epidurogram and right S1 selective nerve root injection.

On October 13, 2009, a CT of the lumbar spine showed L4-L5 laminectomy with rod and pedicle screw fixation. There was incomplete incorporation of the interbody fusion, but there appeared to be good fusion of the facet joint especially on the left.

On October 26, 2009, the patient reported no improvement from the injection and she still continued with right upper buttock pain along with low back pain.

On November 3, 2009, performed a right SI joint injection.

On November 18, 2009, the patient reported greater than 80% relief of lumbar pressure and pain and she was able to function at much greater levels. She was completely asymptomatic, but did note occasional tingling sensation to the posterior aspect of thigh and lower legs. recommended returning to regular activities and maintaining proper body mechanics. Neurontin, Relafen and Soma were prescribed.

2010: From February 17, 2010, through December 30, 2010, the patient remained under the care for her low back issues. She was doing overall better after the SI injection with occasional flare-ups of lumbar pain. encouraged the patient to maintain proper body mechanics, continue medications and avoid any type of heavy lifting.

2011: On March 29, 2011, the patient reported left-sided lumbosacral pain radiating laterally without any specific trauma since one week. She rated the pain at 3-9/10 and was constant. It worsened with direct pressure or extended periods of walking and standing. She also reported left leg radicular pain along the lateral buttocks radiating into the lateral aspect of the knee. She rated it at 7/10 and worsened with activity, motion or elevating the leg. diagnosed lumbar disc derangement, lumbar radiculopathy, lumbar and symptomatic episacral lipoma. recommended lumbar MRI to visualize the patient's spinal canal and surrounding soft tissue. Regarding the lipoma, she was suggested injection. administered left-sided lumbosacral trigger point injection.

On May 8, 2011, an MRI of the lumbar spine revealed laminectomy and interbody fusion grafting with rod and pedicle screw fixation at L4-L5 with wide capacity to the canal and foramina and no significant enhancing epidural fibrosis. The appearance of this was unchanged in the interval since August 2009.

From May 13, 2011, through November 15, 2011, saw the patient for ongoing lumbar issues. reviewed the MRI and recommended stopping Lyrica. After stopping Lyrica, her symptoms started to re-appear. The patient was given

prescription for Medrol Dosepak to help her radicular symptoms. She was recommended to use Relafen and Soma as well as Lidoderm patch occasionally.

2012: From February 14, 2012, through November 28, 2012, the patient continued to be under the care. The patient noted that without the Lyrica, the hyperesthesias along the legs became highly intolerable. Her insurance company denied Lyrica and she was off it for a month. This made her very difficult to get on her day-to-day activities. She reported several incidents where she had struck, twisted her right ankle, hit her right ankle on the corner of the table and spill landing on the right knee. She had a dyskinetic gait and as she was recovering from her ankle and knee, she had an increase in her lumbar pain. prescribed Tylenol, Lyrica, Relafen and Lidoderm patch. Her Soma was changed to Flexeril since it was making her very anxious. This provided her better control of her symptoms.

2013: On February 26, 2013, the patient continued to function well with a little difficulty. Her lumbar pain was still reproducible, but tolerable with use of medications. She rated her pain at 4/10. She reported that her lower extremity radicular symptoms were controlled by Lyrica and overall she was happy. Examination revealed that she was able to stand from a seated position slowly without any pain. The lumbar spine had guarded motion that was limited by stiffness. The lower extremities still had some hyperesthesias on the anterior and lateral aspect of both legs. There were diminished bilateral Achilles reflexes. discontinued Soma and Lidoderm patch and started methocarbamol Mobisyl cream. She was to continue Relafen and Lyrica.

On June 7, 2013, recommended obtaining a lumbar MRI with and without contrast to rule out spinal canal stenosis above or below the fusion.

On July 29, 2013, an MRI of the lumbar spine showed laminectomy and interbody fusing grafting with rod and pedicle screw fixation at L4-L5 with wide capacity to the canal and foramina and no significant enhancing epidural fibrosis. L2-L3 and L3-L4 showed mild facet arthrosis with normal disc configuration. L4 showed artifact from pedicle screws.

On August 9, 2013, the patient noted discomfort with range of motion (ROM) in the lumbar spine. There was tenderness of the lumbar paravertebral musculature. There were decreased bilateral Achilles reflexes. reviewed the lumbar MRI and recommended left L5-S1 transforaminal epidural injection and continuing medications as prescribed.

On September 19, 2013, performed left L5-S1 transforaminal epidural injection with epidurogram and left S1 selective nerve root injection.

On October 4, 2013, noted that the patient had 60% relief in the leg pain and 75% relief in the lumbar spine pain from the injection. Her primary complaint was right-sided lumbosacral pain that exacerbated every time when she stood from a seated position extending her spine or made a sudden movement. She stood

from a seated position very slowly and this caused right-sided lumbosacral pain. She had guarded motion of the lumbar spine with mild suspicion on extension. She had the positive Patrick's test, Spurling's test and right pelvic tilt test. suggested right-sided SI joint injection.

On October 31, 2013, performed a right SI joint injection.

On November 15, 2013, the patient reported complete relief of right-sided lumbosacral pain from the injection. She had suspended the medications and was encouraged to stay active. prescribed Relafen and Lyrica.

2014: On February 17, 2014, the patient noted some generalized lumbar stiffness, but no pain. Her lumbar spine showed guarded motion limited by stiffness in all directions without pain. encouraged her to stay active and continue medications.

On May 16, 2014, noted the patient had fatigue in her legs and she was unable to walk long distances. This discomfort was 8/10. noted that she sounded like she had neurogenic claudication. The patient was recommended lumbar MRI with and without contrast to better evaluate her symptoms.

On May 29, 2014, the request for MRI lumbar spine with and without contrast was denied with the following rationale: *"The patient is a female who was injured on xx/xx/xx, the mechanism of which was not provided in the records submitted for review. She is currently diagnosed with lumbar internal disc derangement, lumbar radiculopathy, and lumbago. A request was made for repeat lumbar MRI. Her surgical history is significant for posterior lumbar decompression and L4-L5 fusion. An MRI was performed on May 8, 2008, which showed no interval changes since August 2009. The imaging was repeated on July 29, 2013. This recent MRI showing postoperative changes (fusion at L4-L5) with no significant enhancing epidural fibrosis. Its appearance was unchanged in the interval since May 2011. The remainder of the study is unchanged as well. She was seen on February 17, 2014, and report that she is very happy with the control of symptoms with use of Lyrica and modification of activities. She is enjoying the benefits of right SI joint injection. There is some generalized lumbar stiffness but no actual pain. There are no lower extremity radicular symptoms. Objective findings noted the patient stands up from a seated position slowly. The lumbar spine has guarded motions that are limited by stiffness in all directions but without pain. The lower extremities are neuromuscularly intact with a negative straight leg raise test and negative Patrick's bilaterally. According to the progress report dated May 16, 2014, the patient is active and is not having low back pain. She does feel fatigue to her legs. She cannot walk long distances before she started having fatigue to the bilateral lower extremities. This discomfort is rated as an 8/10. She is not having much leg radicular pain. She denies any claudication, cramping, varicose veins, DVT or "PE". Physical examination is essentially unchanged compared to the February 17, 2014, report. Lyrica reportedly helps her. Current medication regimen includes Tylenol, Lasix, Lyrica, Soma, Relafen and Lidoderm patches. She received a prescription for Relafen and Lyrica. It was mentioned that the*

patient seems to have neurogenic claudication. A lumbar MRI is being requested to evaluate her symptoms. However, 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 (e.g., tumor, infection, fracture, neuro-compression, recurrent disc herniation). The objective findings did not document significant or progressive neurologic deficits to warrant this study. In consideration of the foregoing issues and the referenced evidence-based practice guidelines, the medical necessity of the request as not been established."

On June 9, 2014, the patient reported that the generalized lumbar stiffness was not very aggressive and only the patient had baseline changes 3/10. However, her bilateral lower extremity fatigue and weakness continued to get worse. She had developed right leg radicular pain along the posterior aspect from the buttocks down the heel with a baseline 8/10. She was aggravated by standing and direct weightbearing and alleviated by heat, rest and medications. Examination revealed lumbar guarded motion limited by stiffness in all directions without pain. She had a positive right leg straight leg raise (SLR) test and negative Patrick's bilaterally. There was diminished right patellar reflex. noted the patient had developed muscular atrophy and diminished neurological function in lower extremities. Therefore, an appeal of her lumbar MRI with and without contrast to evaluate the spinal canal and surrounding soft tissue was made.

Per a reconsideration review dated July 9, 2014, the appeal for MRI lumbar spine with and without contrast was denied with the following rationale: *"The patient is a female who developed low back pain when she "bent down to pick up a container, twisted, and turned" on xx/xx/xx. The current diagnoses are lumbar internal disc derangement, radiculopathy, and lumbago. An appeal request was made for a repeat lumbar MRI. The initial request was not justified due to lack of significant or progressive neurologic deficits. The submitted records now include the December 14, 2006, and June 9, 2014, reports. She has received treatment in the form of medications, activity restrictions, rest, heat application, TENS, PT, ESI, right sacroiliac joint injection, and surgeries. In 2003, she had surgery for a "disc herniation." On August 30, 2005, she received a LESI at L5-S1. On November 17, 2005, she received a facet injection at bilateral L4-L5. On December 21, 2005, an ESI at L4-L5 was performed. On February 23, 2006, she had L4-L5 PLIF with L5-S1 laminectomy. A lumbar MRI on May 5, 2011, showed laminectomy and interbody fusion grafting with rod and pedicle screw fixation at L4-L5 with wide capacity to the canal and foramina; this is unchanged since August 2009. A repeat lumbar MRI on July 29, 2013, demonstrated unchanged findings since May 5, 2011. She presented on June 9, 2014, with lumbar pain graded 8/10 radiating to the bilateral lower extremities; this was associated with weakness. Review of systems was negative for weakness, numbness, and tingling sensation. She was on Tylenol, Lasix, Lyrica, Soma, Relafen and Lidoderm. Lumbar findings guarded ROM, intact neuromuscular functions, and posture SLR test on the right. "Over the last three months, she has progressively developed increased radicular symptoms, muscular atrophy, and diminished neurologic function of the lower extremities." The updated documentation was*

unable to sufficiently address the issues in the previous denial. Discrepancy is noted regarding the claimed neurologic deficits as these were not seen in the examination findings. Clinical progression was still not evident to warrant another lumbar MRI. In agreement with the prior determination, the medical necessity of the request has still not been validated. Additionally, the documentation did not provide evidence of failed outcomes from recent attempts of conservative therapies including physical therapy."

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

The request would be denied at this point based on current medical records provided as well as guidelines. By way of history, this is a claimant who apparently developed low back pain after picking up a container dating back to xx/xx/xx. She has had an extensive history of low back problems with multiple records reviewed indicating prior surgery in the form of posterior lumbar decompression and L4-5 fusion. She had been diagnosed in the past with lumbar internal disc derangement, lumbar radiculopathy, and lumbago. This request has been apparently reviewed on several occasions with denial based on records provided as well as lack of correlation between her clinical findings and the request for repeat MRI. A most recent review dates back to 07/09/14 with the request being denied secondary to discrepancy of claimed neurologic deficits not seen on exam. There was also lack of documentation with regard to failed outcome with conservative treatment. There have been no other records provided since this original denial.

Based upon review as well as the Official Disability Guidelines in this case, there has not been clinical documentation of any significant change in the history or findings clinically on exam. There is no evidence of any clinical worsening or progression as evidenced by exam that would warrant a repeat MRI. Per guidelines, there is no evidence of any history of recent lumbar spine trauma and no evidence of any attempt at recent conservative measures. There is no evidence of any myelopathy noted as well. Therefore, the request would not be recommended as medically necessary.

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

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

Chapter: Low Back - Lumbar & Thoracic (Acute & Chronic) updated 08/22/14

MRIs (magnetic resonance imaging)

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