

# Vanguard MedReview, Inc.

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## IRO CASE #:

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

MRI of the Lumbar Spine with contrast

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

This reviewer is a Board Certified Orthopaedic Surgeon with over 13 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.

### PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a male who was injured at work on xx/xx/xx when he was struck by a plastic roll that was thrown from the floor above him by a fellow employee. 02/11/2013: Lumbar MRI interpreted. **Impression:** 1. Large rightward disc herniation measuring 12 mm at L5-S1 creating moderate to marked right lateral recess and right foraminal stenosis. 2. Posterior disc herniation measuring 8 mm at L1-L2 creating mild central spinal canal with moderate bilateral lateral recess stenosis left greater than right.

03/26/2015: Office Visit. **HPI:** The patient is a gentleman who injured himself at work on xx/xx/xx when he got struck by a plastic roll that somebody had thrown from the floor above him. From his initial injury, the patient underwent a lumbar laminectomy in 2013 that really did not provide him with any significant relief. **Medications:** Hydrocodone, Lorzone, Gabapentin **ADL's:** Pain Intensity: 2 The pain is bad, but I manage with painkillers. Personal Care: 2-I can look after myself, but it causes extra pain. Lifting: 4- Pain prevents me from lifting heavy weight off floor, but can manage from table level. Walking: 6-Pain prevents me from walking more than ¼ mile. Sitting: 6-Pain prevents me from sitting for more than 30 minutes. Standing: 8-Pain prevents me from standing more than 10

minutes. Sleeping: 6-Even when I take medication, I sleep less than 4 hours. Sex Life: 2- My sex life is normal, but causes extra pain. Social Life: 2-My social life is normal, but increases my pain. Driving: 6- Pain restricts me from driving less than 1 hour. **Review of Neurodiagnostic Studies:** I have reviewed the MRI scan of the cervical spine that demonstrates loss of cervical lordosis with multilevel cervical spondylosis with disc herniation and stenosis from C3-4 all the way to C6-7. His triceps was 4+/5, deltoids 4+ to 5/5, biceps 4+ to 5-/5. **Assessment/Plan:** ICD: Cervical Radiculopathy Plan: MRI Lumbar Spine with CM. ICD: Lower back pain ICD: Displacement of lumbar intervertebral disc without myelopathy. I would recommend the patient get an MRI scan of the lumbosacral spine with contrast to evaluate for possible recurrent disc herniation versus scar tissue at the L5/S1 level on the right. Without contrast it is impossible to differentiate scar tissue from recurrent disc herniation. With regards to the cervical spine I have offered him C3-4, C4-5, C5-6, C6-7 anterior cervical discectomies and fusion using bone marrow aspirate and allograft. The risks of infection, bleeding, stroke, paralysis, death, dysphonia, dysphagia and ongoing pain have been discussed with the patient and the patient wishes to proceed with surgery.

04/23/2015: UR. **Rational for Denial:** The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The patient is a xx year old male who sustained injury to the low back due to a fall on xx. He is diagnosed with low back pain and lumbar intervertebral disc displacement. Documented treatment includes medications, LESI, and surgery. MRI on 2/11/13 revealed a large rightward disc herniation measuring 12mm at L5-S1 creating moderate to marked right lateral recess and right foraminal stenosis. There was a posterior disc herniation measuring 8mm at L1-2 creating mild central spinal canal with moderate bilateral lateral recess stenosis left greater than right. The patient subsequently underwent lumbar decompressive surgery on the left at L5-S1 on 10/04/13. The patient's low back condition was declared at maximum medical improvement (MMI) on 4/17/14. Per the 3/26/15 report, the patient was seen in the clinic for follow-up visit and to review the results of the cervical spine MRI. He also complained of low back pain. His medication regimen included hydrocodone, Lorzone, and gabapentin. Examination showed a well-developed and well-nourished patient. He was alert and oriented. No lumbar spine examination was performed. His cervical spine MRI was reviewed. Lumbar spine MRI with contrast was requested to evaluate for possible recurrent disc herniation versus scar tissue at the L5-S1 on the right. Current request is made for MRI of the lumbar spine without contrast. The ODG state a repeat MRI may be done when there is significant change in symptoms and/or findings suggestive of significant pathology. However objective evidence of neurologic compromise that correlated with the medical history was not documented. Objective evidence of radiculopathy was not noted. There was no documented considerable change in the patient's symptoms, or significant nerve root dysfunction or neurologic progression to warrant repeat MRI of the lumbar spine. Given the above information, the medical necessity of this request is not substantiated. As such, the request is non-certified. Addendum: Via phone call, I discussed the case. Who noted that the patient had lumbar surgery in 2013, a subsequent MRI was without contrast, and cannot differentiate between scar and disc. The provider noted, the

request is for MRI with contrast for delineation. The provider stated the patient had lumbar radiculopathy, the chart was not available for objective findings, and I was authorized to call the office and obtain information for radicular signs on exam. I called the office and left a message. Further information is pending. No additional information was provided. As such, the request is non-certified.

04/30/2015: UR. **Rationale for Denial:** This patient is a male who was injured on xx/xx/xx when he got struck by a plastic roll that somebody had thrown from the floor above him. He is diagnosed with cervical radiculopathy, low back pain, and displacement of lumbar intervertebral disc without myelopathy. An appeal request was made for MRI of the lumbar spine with contrast. The request was previously denied because there was no objective evidence of neurologic compromise that correlated with the medical history, objective evidence of radiculopathy, or change in the patient's symptoms, or significant nerve root dysfunction or neurologic progression. Documented treatments include medications, physical therapy, and epidural injection. MRI of the lumbar spine by dated 2/11/13 showed a large rightward disc herniation measuring 12 mm at L5-S1 creating moderate to marked right lateral recess and right foraminal stenosis. There was a posterior disc herniation measuring 8 mm at L1-2 creating mild central spinal canal with moderate bilateral lateral recess stenosis left greater than right. The patient underwent left L5-S1 hemi laminectomy and micro discectomy on 10/4/13. During the 3/26/15 follow-up, the patient complained of low back pain. Current medications include hydrocodone, Lorzone, and gabapentin. Physical examination showed a well-developed and well-nourished patient. He was alert and oriented. Examination of the lumbar spine was not performed. Motor testing showed weakness of the triceps (4+/5), deltoids (4+ to 5-/5), and biceps (4+ to 5-/5). MRI of the lumbar spine was requested to evaluate for possible recurrent disc herniation versus scar tissue at the L5-S1 level on the right. There was no updated documentation submitted to address the previous reasons for denial. Guidelines state that repeat MRI is recommended when there is significant change in symptoms and/or findings suggestive of significant pathology including, but not limited to, tumor, infection, fracture, neurocompression, and recurrent disc herniation. However, the medical records submitted for review did not indicate a progression of symptoms, or raise suspicion for other significant pathologies. Therefore, the request for MRI of the lumbar spine is not medically necessary, and the previous determination is upheld.

05/21/2015: Office History. **HPI:** is a gentleman who I had seen back in November of 2014 with complaints of neck, thoracic, and low back pain that started after work-related injury on xx. The patient was at work when somebody had thrown a plastic roll from the floor above him, which ended up hitting him and thrusting him forward. The patient had loss of consciousness and since then has had troubles with his spine. The patient had undergone lumbar laminectomy in 2013 as a result, which has not provided him with long-term relief. The patient is scheduled to undergo multilevel anterior cervical discectomy and fusion with which he wishes to proceed. The patient at this visit states he continues to have difficulties with headache and neck pain and numbness and tingling in his arms with weakness. **Past Medical History:** Headaches. **Past Surgical History:** Lumbar Laminectomy

in 2013 **Neurological Examination:** He had diffuse weakness in both upper extremities, which I graded at 4+/5 with pain on palpation of his cervical spine posteriorly, where he is quite tender. The patient also has weakness in his lower extremities. **Neurodiagnostic Studies:** He had an MRI scan of the cervical spine that demonstrates multilevel cervical spondylosis with stenosis and disk herniations from C3-4 all the way to C6-7. **Impression:** Impression is that of a xx year old gentleman with a work-related injury on xx with cervical, thoracic, and lumbar spinal pain with multilevel cervical disk herniations. **Recommendations:** I have discussed doing a C3-4, 4-5, 5-6 and 6-7 anterior cervical discectomy and fusion using bone marrow spicate and allograft with him. I have gone over the risks, benefits, and alternatives of the surgery with him and he wishes to proceed. I have answered questions to his complete satisfaction. The patient also understands that he cannot smoke after the surgery, as he is going to be at high risk for pseudo arthrosis and failure. The risks of dysphonia, dysphagia have also clearly been discussed with him.

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

The previous adverse determinations are upheld. This patient does not require a MRI of the lumbar spine with contrast. has undergone a discectomy at L5-S1 on 10/4/13. According to the designated doctor report of 4/17/2014, a lower extremity EMG/NC study did not demonstrate any evidence of cervical or lumbar radiculopathy. On examination, he had diffuse weakness of the entire right leg, associated with multiple nerve roots graded 2-3/5 in strength. recent office note of 5/21/2015 indicated weakness in the lower extremities, without reference to a specific pattern consistent with pathology at L5-S1. The Official Disability Guidelines (ODG) supports repeat MRI studies of the lumbar spine when there is a significant change in symptoms or findings suggestive of significant pathology. Based on the records reviewed, there is no evidence of recurrent disc herniation at L5-S1. The patient had no radicular complaints in the records reviewed. The patient's diffuse lower extremity weakness can be attributed to his cervical pathology. A lumbar spine MRI with contrast is not medically necessary for this patient.

Per ODG:

#### **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
- Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)

**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)**