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**Date notice sent to all parties:** 09/17/15

**IRO CASE #:**

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

Lumbar MRI without contrast

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

Board Certified in Orthopedic Surgery  
Fellowship Trained in Spinal Surgery

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Lumbar MRI without contrast - Upheld

**PATIENT CLINICAL HISTORY [SUMMARY]:**

On XX/XX/XX, examined the patient. He had no specific neurological loss and had a right sided antalgic gait. Straight leg raising was negative and motor strength was 5/5. Sensation was intact. noted he knew the patient had stenosis secondary to graft collapse at L5-S1 and a selective nerve root block did help his pain. It was felt he was a poor surgical candidate due to his psychological status. On 12/11/96, the patient was unchanged in his back and had a new complaint of right shoulder pain that was not related to his neck. He had no other pain, weakness, or paresthesias into his arm. A subacromial injection was performed. A lumbar MRI dated 02/08/09 revealed status

post interbody fusion at L4-L5 and L5-S1. There was a minimal ventral circumferentially bulging disc at L3-L4. There was very slight posterior compression of the thecal sac at L3-L4 without bony spinal stenosis. A lumbar CT myelogram on 05/23/01 revealed a well ossified posterolateral fusion and well ossified interbody fusion at L4-L5 and L5-S1. There was mild stenosis of the spinal canal, lateral recesses and neural foramina at L3-L4, slightly more pronounced to the left and the result of degenerative change. There was mild bulging of the annulus at L2-L3.

On 07/27/01, noted the patient's pain was well controlled on Vioxx and occasional Lortab. He felt the CT myelogram looked fine and the patient was at MMI. No further surgery was planned. reexamined the patient on 12/16/03. He noted he had persistent cervical and lumbar pain and Lodine was not "cutting it". He was permanent disability. Lumbar flexion was 90 degrees, hyperextension was 15 degrees, and side bending was 20 degrees. He was tender from L1-S1. Ultracet was prescribed and home exercises were reviewed. On 09/13/07, the patient returned to. He denied any radiation of pain down his lower extremities. He was taking Mobic and Ultracet. He had limited lumbar range of motion and his neurological exam was normal. He was advised to continue home exercises and Tramadol and Mobic were prescribed. On 10/03/11, noted the patient had an L3-L4 ESI recently with great relief and it really helped his leg pain. felt the spondylolisthesis at L3-L4 was the source of his pain and it was felt he might be a candidate for a Corflex device or a DLIF fusion procedure. The MRI dated 12/05/11 revealed a well ossified fusion from L4-S1 and degenerative change and Grade I anterolisthesis at L3-L4 resulting in severe spinal stenosis. The stenosis at this level was slightly more pronounced than the CT scan of 12/05/11. There was mild spinal stenosis at L2-L3. On 03/26/12, documented a normal neurological exam. The patient denied paresthesias, weakness, and difficulty with gait/balance. It was noted he now had spinal stenosis at L3-L4 and it was noted he had claudication leg pain, but no neurological deficits. A repeat ESI at L3-L4 and therapy were recommended. On 05/01/12, performed an ESI. On 07/02/12, noted the patient was not doing well with rehabilitation and counted with pain. Surgery was recommended. On 08/06/12, direct lateral interbody fusion at L3-L4 with open decompression at L3-L4 and revision posterior instrumental fusion at L3-L4, L4-L5, and L5-S1. On 08/09/12, the carrier filed a DWC PLN-11 denying the requested lumbar surgery. On 04/22/13, noted the patient had low back pain and bilateral leg radicular pain. It was noted x-rays from one year prior showed 1 mm. from flexion to extension. It was felt his spondylolisthesis at L3-L4 was unstable and a new MRI was recommended. Another lumbar MRI was performed on 05/02/13 and the findings were the same as 12/05/11. On 08/05/13, reviewed the MRI and the DLIF procedure was again recommended. He felt the spondylolisthesis and stenosis was related to adjacent level disease and was therefore part of the compensable injury. On 02/03/14, noted the patient still had claudication components and was a surgical candidate. On 04/17/14, Norco 10/325 mg. was requested. On 08/04/14, noted the patient's pain had not changed and he was neurologically intact. He had restricted range of motion and tenderness. His medications were refilled. On 02/03/15, he had no significant change and Hydrocodone was refilled. On 04/21/15, the patient informed his pain was unchanged and his neurological exam was the same. He was switched from Hydrocodone to Norco at that time. The patient returned to on 07/17/15. His low back pain radiated down his left buttock into his left thigh and he had been maintained on high dose narcotics, as surgery was never done. He was on four

Norco per day and he had pain in his left groin that was worsened with ambulation. He had pain with range of motion of the left hip and he had a positive sciatic notch on the left. He had mild hip flexor weakness on the left. X-rays revealed the previous fusion at L4-L5 and L5-S1 with hypertrophic facet joints and multilevel spondylosis and decreased joint space with cystic changes on at the left acetabulum. The impressions were stenosis at L3-L4 with progressive neurogenic claudication in L4 pattern on the left and osteoarthritis of the left hip. Repeat imaging of the lumbar spine was recommended and Norco would be continued. He would be sent for evaluation for total hip arthroplasty. On 07/29/15, provided an adverse determination for the requested lumbar MRI without contrast. On 08/07/15, followed-up with the patient. He had the same back pain, leg pain, and functional problems. His gait was slow, but normal on exam. His range of motion was restricted and he had mid lumbar tenderness. He was neurologically intact. stated he felt the L3-L4 spondylolisthesis was causing his pain and they would appeal the lumbar MRI. On 08/26/15,, also on behalf, Provided another adverse determination for the requested lumbar MRI without contrast.

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

There has been no objective change in the patient's condition based on the documentation provided for review at this time. As of 02/09/14, he had normal sensation and a normal neurological examination. As of 08/04/14, he was still neurologically intact. On 02/03/15, he had no significant change in his condition and was functional on his medications. No examination was documented. On 04/21/15 documented the patient's neurological examination was unchanged and his pain was unchanged. On 07/17/15 noted the patient presented for his neurogenic claudication and low back pain. His pain radiated down his left buttock into the left thigh. X-rays revealed hypertrophic facet joint and multilevel spondylosis, decreased joint space with cystic changes in the left acetabulum. Repeat imaging was recommended at that time. Based on the documentation provided, the patient has been subjected to prior MRI scans and CT myelograms and they have demonstrated his condition of a previous fusion and degenerative changes. In the absence of objective neurological change, the ODG does not recommend repeating diagnostic studies, such as MRIs. There is no significant change in his symptoms or red flags that would warrant an updated MRI at this time. There is no necessity to have an MRI to fashion an appropriate therapeutic plan. This patient is not a candidate for surgery given the lack of objective findings and there is no indication to repeat the diagnostic study. Therefore, the requested lumbar MRI without contrast is not medically necessary, appropriate, or in accordance with the ODG and the previous adverse determinations should be upheld at this time.

**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)**