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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
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

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

☒ Overturned (Disagree)

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]:
Patient is a XXXX who presents with XX XX pain that radiates down XXXX XX side. XXXX. XXXX has had physical therapy and has taken anti-inflammatories and pain medications. The insurance company is denying an MRI of the XX XX.

XXXX: MRI of the XX XX without contrast. Clinical history: M54.16. Impression: 1) 4mm XX XX XX protrusion at XX-XX, which contacts the inferior surface of the exiting XX XX nerve root. There is mild degenerative XX joint hypertrophy at this segment as well. The combination results in moderate XX XX and lateral recess XX. 2) 4mm XX bulge at XX-XX, which mildly impinges upon the XX XX. There is mild degenerative XX and ligamenta flava hypertrophy resulting in severe lateral recess and moderate XX XX. 3) 2mm XX bulge at XX-XX. 4) Moderate degenerative XX joint hypertrophy bilaterally at XX-XX and on the XX XX-XX. 5) Mild degenerative XX joint hypertrophy at XX-XX and XX-XX. 6) Mild XX desiccation and degenerative spondylosis from L1-XX through XX-XX.

XXXX – CT Scan Report (Incomplete)- XXXX: (Page One-Missing.) Page Two: 2) At XX-XX there are multiple findings, including a 3mm XX XX herniation that results in moderate XX XX XX narrowing and XX XX lateral recess encroachment. 3) At XX-XX there is a 6mm XX herniation that extends across the XX interspace resulting in XX XX

with a XX XX diameter of 8mm and XX greater than XX lateral recess encroachment. 4) At XX-XX there is severe XX and mild XX XX narrowing due to XX hypertrophy and to a lesser extent XX osteophyte. 5) At XX-XX there is moderate XX XX encroachment due to severe XX XX hypertrophy.

XXXX – Physician Notes-XXXX: Chief complaint: XX and XX leg pain; Review of XX CT. HPI: This XXXX is seen today for review of XX CT. The XX CT was reviewed by report and by actual study and was consistent with central and XX XX on the XX at XX-XX, and lateral recess and XX XX narrowing at XX-XX and XX-XX. XXXX notes no change in XXXX complaints of XX leg pain and numbness. The patient has had no additional treatment since the last visit. Assessment: -XX XX XX XX.XX/XX.XX. Plan: -The patient could consider decompression which would include the central and XX side at XX-XX and the XX at XX-XX and XX-XX. XXXX has some XX at each level and XXXX exam is somewhat missed as to level of abnormality. XXXX has XX media knee and XX foot numbness that points toward XX-XX and XX-XX but also has absence of the XX Achilles reflex on initial visit and today which speaks to the XX-XX level. I feel it is probably best to locally decompress each of the 3 lowest levels. XXXX has had conservative treatments including injections. XXXX realizes any decompression surgery is directed at leg pain and not XX pain and that numbness may persist even with a good result as it relates to pain relief. –I have discussed the risks and benefits of surgery versus physical therapy, epidural steroids and other conservative forms of treatment. –I described the surgical procedure in detail and advised the patient of the pros, cons and risks of the surgery. The risks included, but were not limited to bleeding requiring blood transfusion, risk of infection and intraoperative nerve damage that could result in persistent pain, weakness, numbness, bowel/bladder dysfunction, and sexual dysfunction. A remote risk of death was explained. Future surgery for infection, XX fluid leak, or other complication was explained as being possible. The usual but not guaranteed postoperative course was outline. Multiple medical complications were stated to be possible. The patient is advised that risks are also outlines on the consent form for the surgery. The patient's rehab nurse here for this visit and counseling session. –The patient would like to consider the possibility of the surgery option. XXXX notes that XXXX is leaning toward surgery and will get XX to me. I will have XXXX come in for pre-op visit if XXXX decides in favor of surgery. XXXX will see XXXX treating MD tomorrow and I will get this report to XXXX. –Call or return if symptoms worsen or persist.

XXXX – Operative Report-XXXX: Pre-operative Diagnosis: XX-XX, XX-XX, and XX-XX XX XX; Severe radicular XX leg pain. Post-operative Diagnosis: Same. Operations Performed: XX-XX XX, XX, XX XX and XX (XX at XX-XX and XX at XX-XX and XX-XX). Description of Procedure: Under adequate general endotracheal anesthesia the patient was placed in the prone position on the operative table and the XX was prepped and draped in sterile fashion. The image-intensifier and a metal marker were used to confirm the appropriate location for incision. The incision was made in the midline over the appropriate interspaces and the dissection was carried through the subcutaneous tissues. The XX XX was identified and was incised. Subperiosteal stripping was accomplished and the retraction was gradually deepened. The fluoroscopy unit and a metal marker were used to provide radiographic confirmation of the XX-XX level. The XX was next started with a power burr

and was completed with Kerrison rongeurs. The protuberant XX was visualized and incised with a #XX. The nerve root and XX XX were gently mobilized and protected with a nerve XX. XX was accomplished using variously configured XX XX until no addition fragments were obtained. XX XX XX and XX was accomplished with XX. The contralateral XX side was decompressed across the XX beneath the XX process and the XX structures were not violated. The neural elements were now highly mobile to gentle palpation with a XX and a XX nerve XX was able to be passed easily down the neural foramen as well as proximally and distally within the epidural space without any obstruction. Therefore, the decompression was complete. A similar decompressive procedure was next performed at the XX-XX and also at XX-XX (but decompression was needed only on the XX) using the same instruments in approximately the same fashion as described above until full decompression was accomplished. Copious antibiotic irrigation was performed and meticulous hemostasis was completed. The wound was closed in layers without using a drain with XXXX used for the deeper layers and subcuticular XXXX used for the skin closure. XX glue and XX were applied and a dressing was placed. The patient was turned to the XX position and XX. There was unchanged XX status in the recovery room. The patient tolerated the procedure without difficulty or complication with an estimated blood loss of XX. No blood was transfused and all counts were correct. The patient received antibiotics intravenously preoperatively with plans being made to continue the antibiotics postoperatively.

XXXX – Operative Report-XXXX: Chief complaint: -Postop decompression. HPI: This XXXX is seen today for postop XX XX-XX, XX XX-XX and XX-XX decompression follow up. The patient states that the leg pain has partially improved. The wound has been closed subcuticularly and there does not appear to be any wound drainage. The patient has increased tenderness proximal to wound with localized edema. XXXX reports XX grade fever prior to visit today, XXXX degrees. XXXX also reports some wound drainage prior to today's visit. XXXX states XXXX now has XX leg pain to the knee only, which has improved over XX leg pain to foot. XXXX pain level has stabilized overall since XXXX was seen by XXXX treating physician XX days ago. XXXX is now taking XXXX which works better than XXXX for pain. Patient is seen today with XXXX nurse case manager. Assessment: -XX XX XX XX.XX/XX.XX, treated with decompression XX XX-4, XX XX-5, XX-XX. Plan: Orders: -x-ray XXXX; XX; XX; XX, XX; -XX. Medications: XXXX: Take one XX XX times daily x 1 week. Instructions: -The patient should be ready for therapy subsequent to the next visit. –Labs for XX markers will be obtained. – XXXX x XX week. –Follow up by phone x one week or if any problem, fever, or wound drainage sooner. –XXXX remains off work. –Wound localized tenderness and mild swelling appears to be suture abscess from the knot at XX incision. Return visit request in/on 2 weeks +/- 2 days.

XXXX – Physician Notes-XXXX: Chief complaint: XX and XX leg pain; Review of treatment progress; Follow up of XX decompression. HPI: This XXXX is seen today for follow up of XX decompression XX sacrum. The patient states that the decompression has been moderately helpful. The patient has had therapy since the last visit. The therapy has been helpful. Patient was doing well until XXXX states XXXX XX knee "gave way" yesterday. XXXX complains of same XX sided pain that refers into XX leg now involving XXXX shin and XX of foot. XXXX is extremely uncomfortable and tries to keep all weight

off XX leg and foot. Assessment: -Inflammation of XX sacroiliac joint XX/XX.1; -XX XX XX XX.XX/XX.XX. Plan: Orders: -X-ray XX XX; - XXXX; Injection XX joint-RT. The patient was agreeable to XX injection today. Pressing XXXX XX XX joint produces XXXX XX leg pain into the foot. This was accomplished after verbal counseling and patient consent and is dictated separately as a procedure code. The use of OTC anti-inflammatory medications were discussed with the patient. XXXX will take XXXX with each meal (3x/day) instead of XXXX. Patient may resume PT after XXXX's seen by XXXX on XX. XXXX was doing better prior to XXXX knee giving way earlier this week. Patient's gait pattern improved quite a lot after the XX injection. Follow up in four weeks. XXXX might require additional injection for the XX pain if XXXX had temporary relief.

XXXX – Physician Notes-XXXX: Chief complaint: XX pain; XX XX pain. HPI: XXXX who is self-referred for XX-XX pain and XX side. The XX-XX pain developed gradually XX months ago. XXXX XX-XX pain is 9/10 in severity and has a sharp and shooting pain and radiates into the XX leg. The pain occurred as a result of: no particular even recalled. Patient reports that XXXX pain on worst day is 9/10 and 5/10 on XXXX best day. It is aggravated by bending, sitting, standing, stretching, twisting and walking. The pain is mitigated by nothing. XXXX denies any additional symptoms. The patient has no prior history of XX or XX surgery. XXXX has been previously treated with PT and anti-inflammatory medications. The PT was ineffective in relieving the pain. The patient presents to the clinic with c/o XX pain related to work injury in XXXX. XXXX chief complaint is for XX XX XX pain that radiates down XX XX extremity XX. XXXX is currently taking XXXX. XXXX was previously a patient of XXXX. XXXX has been doing PT which is somewhat effective. XXXX last MRI/X-ray was performed in XXXX. Past medical records were not available for review. On XXXX: Patient returns for a follow up visit for XX-XX and XX side of the body pain. Patient reports no new symptoms since last visit. XXXX reports XXXX pain level to be 4/10. XXXX reports XXXX is now taking XXXX. XXXX reports no new side effects since last visit. Assessment: -Chronic pain XX; -Encounter for long-term (current) drug use XX; -XX XX of XX region XX.XX/XX -XX XX. Plan: Orders: -Request medical records; Medication refill; Psychological testing; XXXX; MRI XX XX w/w/o contrast. Patient with work related injury while XXXX. Last seen in our office XXXX. Patient underwent XX decompression surgery on XXXX. Patient states XXXX fell XX weeks ago due to "knee giving out." Imaging performed in XXXX office and patient states XXXX did not see any abnormalities. XXXX continues to have worsening XX pain with sharp radiation pain to XX foot. Will request records. XXXX also followed up with XXXX last week who recommended XX MRI. MRI XX XX ordered. I will prescribe XXXX ineffective. Will also prescribe XXXX; samples provided for titrating dose. XXXX caused agitation in the past. Continue XXXX given for XX pain exacerbation. XX.

XXXX – Physician Notes-XXXX: Chief complaint: XX pain. HPI: This XXXX is seen today for follow up of XX decompression. The patient states that the decompression has been associated with little relief of XXXX XX and XX proximal leg pain. XXXX does note that the XX XX injection was very useful for a short time and requests another injection. I believe XXXX pain MD has discontinued XXXX therapy and ordered a follow up MRI. The patient has had no additional treatment since the last visit. Assessment: XX XX XX

XX.XX/XX.XX. Plan: Orders: -TWCC; XXXX; Injection XX joint-RT. The patient was agreeable to XX injection today. This is, so far, the only technique that has helped XXXX significantly post-op. This was accomplished after verbal counseling and patient consent and is dictated separately as a procedure note. I will review the planned post-op MRI. XXXX simply is not able to work currently. XXXX has significant pain in any position including sitting and there may be a risk in working with this level of discomfort. XXXX has fallen on occasion. I will see XXXX in one month but will review the MRI when available.

XXXX – URA Determination-XXXX, as the delegated agent for the insurer, has reviewed the prescribed plan of treatment: MRI of the XX XX with and without contrast, as outpatient. Determination: Recommend prospective request for MRI of the XX XX with and without contrast, as outpatient between XXXX be non-certified. Rationale: XXXX with a date of injury XXXX. The injury occurred while XXXX. XXXX was seen by XXXX on XXXX with the complaints of XX-XX and XX-sided XX XX pain. The XX-XX pain had developed a few months prior and was rated 9/10 at the time. The pain radiated to the XX leg. The pain was rated 9/10 at its worst and 5/10 at its best. The pain was aggravated by bending, sitting, standing, stretching, twisting and walking. The examination findings included tenderness to palpation of the lumbosacral paraspinal muscles, positive straight leg raise test on the XX, decreased sensation laterally and XX in the XX XX extremity and an antalgic gait with ability to stand without difficulty. An assessment of chronic pain syndrome was made. Per an addendum dated XXXX, an MRI of the XX XX with and without contrast was ordered. A prior imaging (MRI/X-ray) was performed on XXXX. The records were not available for review. Treatment included physical therapy (ineffective in relieving pain), anti-inflammatory medications, XX decompression surgery and pain medications (XXXX). Based on the clinical information provided, the request for MRI of the XX XX with and without contrast, as outpatient is not recommended as medically necessary. The submitted progress report dated XXXX indicates that the patient has no yellow flags and no red flags. XXXX last MRI was performed in XXXX. This report is not submitted for review. There is no rationale provided to support a repeat MRI at this time. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

XXXX – Status Report: Follow up Evaluation- XXXX: Date of initial visit: XXXX; Date of injury: XXXX; Last worked: XXXX. Description of Injury: XXXX, R side XX XX/XX-XX; pain scale 7-8/10 also feeling pain to XX leg. Patient was seen at XXXX. Subjective Complaints: DOI XXXX patient states that XXXX is here on a f/u injury. PL XX. XX XX: Patient states that overall the symptoms have increased. Pain decreased. Pt reports a pain level of 3. ROM remains the same. Radiating pain has remained the same. Numbness and tingling remained the same. XX extremity weakness remained the same. No loss of bowel/bladder control. No saddle anesthesia. XX XX: Inspection healing scar. XX deviation to remains the same. XX remains the same. ROM decreased in all planes. Muscle spasm along the XX muscles remained the same. Tenderness remained the same. XX extremities: XX intact: Yes. Deep tendon reflexes hypoactive. Sensation normal. Muscle strength decreased RLE. Special testing sitting SLR XX positive. Sitting XX XX negative. XX XX XX positive. Gait normal: No. Diagnosis: Sprain of ligaments of XX XX,

subsequent encounter XX.XX. Recommendations: 1) Physical therapy evaluation and treat on sprain of ligaments of XX XX, subsequent encounter for essential functions, XX education, and functional improvement. 2) Medication: XXXX 3) MRI not approved, adjuster has asked that we put the order in MRI with and without contrast. 4) XX XX weeks. 5) Diagnostic Imaging/Testing: MRI on XX XX XX with contrast. Work status: Restricted duty.

XXXX – URA Re-Determination- XXXX, as the delegated agent for the insurer, has reviewed the prescribed plan of treatment: Reconsideration for MRI of the XX XX with and without contrast, as outpatient. This is a re-review. Determination: Recommend prospective request for Reconsideration for MRI of the XX XX with and without contrast, as outpatient between XXXX be non-certified. Rationale: The claimant is a XXXX who sustained an injury to the XX XX on XXXX. XXXX. The claimant was diagnosed with sprain of ligaments of the XX XX; XX XX, XX region and radiculopathy, lumbosacral region. An MRI of the XX XX dated XXXX revealed: 1) 4mm XX XX XX protrusion at XX-XX, which contacts the inferior surface of the exiting XX XX nerve root. There is mild degenerative XX joint hypertrophy at this segment as well the combination results in moderate XX XX and lateral recess XX. 2) XXmm XX bulge at XX-XX, which mildly impinges upon the XX. There is mild degenerative XX and ligamenta flava hypertrophy resulting in severe lateral recess and moderate XX XX. 3) 2mm XX bulge at XX-XX. 4) Moderate degenerative XX joint hypertrophy bilaterally at XX-XX and on the XX at XX-XX. 5) Mild degenerative XX joint hypertrophy at XX-XX and XX-XX. 6) Mild XX desiccation and degenerative spondylosis from L1-XX through XX-XX. On XXXX, an order was made for an MRI of the XX XX with and without contrast by XXXX. According to the follow up evaluation by XXXX, there was documentation of XX XX XX/XX-XX pain radiating to the XX leg rated at 3/10. In addition, there was documentation of unchanged numbness, tingling and XX extremity weakness. The physical exam revealed the claimant had an antalgic gait; the claimant appeared to be in mild distress and anxious; XX XX exam showed a healing scar; lateral deviation remained the same; lordosis remained the same; decreased range of motion in all planes; muscle spasm along the paraspinal muscles remained the same; tenderness remained the same; XX extremities exam showed deep tendon reflexes were hypoactive; decreased muscle strength XX XX extremity; positive seated and supine SLR. The remainder of the exam was unremarkable. The assessment included a diagnosis of sprain of ligaments of the XX XX. The treatment plan included MRI of the XX XX XX with contrast and a follow up on XXXX. Other recommendations included physical therapy, XXXX. The claimant was released for modified duty. In this case, the patient has pain complaints into the XX leg, and has sensory changes in the XX leg. Patient needs to go XX to XX surgeon. Somebody needs to explain what "imaging" was done by XXXX, if indeed any occurred, and when; and XXXX s response to such imaging. Somebody needs to assess the patient's exam that knows XXXX and can indicate what subjective complaints are new or old, and what exam findings are new or old. Therefore, the request for Reconsideration for MRI of the XX XX with and without contrast, as outpatient, is not medically necessary.

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

The request for MRI of the XX XX has been found to be medically necessary and is approved. I am overturning the previous decision to refuse coverage for the MRI of the XX XX.

The patient is a XXXX who injured XXXX. XXXX underwent a XX decompression XX-sacrum in XXXX. XXXX continues to have XX pain with radiation into the XX XX extremity. According to the medical record, XXXX has decreased XX motion, muscle spasm and tenderness. XXXX has decreased muscle strength in the XX XX extremity with a positive straight leg raise sign. The treating physician has recommended a MRI study of the XX XX with contrast.

The Official Disability Guidelines (ODG) supports MRI studies of the XX XX in patients with uncomplicated XX XX pain, who have a history of prior XX surgery.

This patient continues to be symptomatic following XX surgery. It is standard practice to re-image the XX XX with MRI following a failed XX surgery. XXXX contrast is routinely used in post-op MRI of the XX XX to distinguish between recurrent XX herniation and scar tissue.

The XX XX MRI with and without contrast is medically necessary for this patient. The results of this study will determine whether the patient will require further treatment.

Per ODG:

ODG Criteria

<u>Indications for imaging</u> -- Magnetic resonance imaging:
- Thoracic XX trauma: with neurological deficit
- XX XX trauma: trauma, neurological deficit
- XX XX trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)
- Uncomplicated XX XX pain, suspicion of cancer, infection, other “red flags”
- Uncomplicated XX XX pain, with radiculopathy, after at least 1 month of conservative therapy, sooner if severe or progressive neurologic deficit.
- Uncomplicated XX XX pain, prior XX surgery
- Uncomplicated XX XX pain, cauda equina syndrome
- Myelopathy (neurological deficit related to the XX 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 (e.g., tumor, infection, fracture, neurocompression, recurrent XX 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 XX XX 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)**