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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: August 17, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the lumbar spine, with and without contrast.

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

M.D., Board Certified in Radiology.

REVIEW OUTCOME

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The requested MRI of the lumbar spine, with and without contrast, is not medically necessary for the evaluation of this patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 7/30/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/31/12.
3. Notice of Assignment of Independent Review Organization dated 7/31/12.
4. Medical records.
5. Letter from dated 7/24/12.
6. Undated preauthorization request form.

7. Imaging of the lumbar spine dated 7/11/12.
8. Document entitled Employee's Report of Injury.
9. MRI of the cervical spine.
10. MRI of the lumbar spine.
11. CT of the cervical spine with cervical x-rays.
12. Cervical and lumbar myelogram and CT.
13. Functional performance evaluation summary.
14. Lumbar spine x-rays.
15. Lower extremity nerve conduction velocity, dermatomal/somatosensory evoked potential and needle EMG study.
16. Lumbar spine x-rays dated 6/01/09, 2/02/10, 9/14/11 and 7/11/12.
17. Qualitative functional capacity evaluation dated 9/22/11 and 12/13/11.
18. Medical records dated 6/24/09.
19. Mental health evaluation dated 9/22/11.
20. PT gym results report dated 10/19/11 through 12/09/11.
21. OT gym results report dated 10/10/11 through 12/15/11.
22. Records from OTR dated 10/06/11 through 10/10/11.
23. Disability assessment dated 10/10/11.
24. Physical therapy evaluation dated 10/06/11.
25. Medical records from OTR dated 10/12/11 through 12/05/11.
26. Medical records from PT, DPT dated 10/12/11 through 12/05/11.
27. Document entitled Phase II Evaluation.
28. Letter from MD dated 10/12/11.
29. Document entitled Comprehensive Evaluation dated 10/20/11 and 11/17/11.
30. Letters from MD dated 9/20/11, 9/22/11, 10/19/11, 10/27/11, 11/10/11 and 12/13/11.
31. Medical records from MD dated 10/20/11 through 12/05/11.
32. Medical records from OTR dated 11/21/11.
33. Medical records from PT dated 11/21/11.
34. Fitness maintenance plan dated 12/02/11.
35. Discharge plan dated 12/05/11.
35. Medical records from MD dated 3/22/12.
36. Operative report dated 4/20/12.
37. Document entitled Summary dated 1/29/09.
38. Impairment rating report dated 5/17/00.
39. Medical records from unlisted provider dated 5/16/00.
40. Range of motion testing dated 5/16/00.
41. Letter from MD dated 8/04/06.
42. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female injured in a motor vehicle accident. An MRI of the lumbar spine revealed disc desiccation at L4-L5. There was minimal posterior bulging of the annulus fibrosis. At L5-S1, there was marked disc desiccation and anterior endplate spur formation. There was signal dropout within the interspace, likely indicating vacuum disc phenomenon. There was

posterior endplate spur formation and diffuse posterolateral annular bulging, resulting in bilateral mild L5 neural foraminal narrowing. There was mild bilateral degenerative facet hypertrophy. Electrodiagnostic studies performed on 8/14/00 were normal, without evidence of radiculopathy. Radiographs of the lumbar spine performed on 2/02/10 revealed metal and bony L4-S1 fusion in anatomic position. A functional capacity evaluation performed on 9/22/11 placed the patient in the below sedentary physical demand level, while her occupation required a very heavy physical demand level. The patient attended physical therapy and occupational therapy from October 2011 through December 2011.

On 3/20/12, the patient reported low back pain and right leg pain rated as 8 out of 10. The medical note indicated that the patient was weaning herself off OxyContin. Physical examination revealed tenderness of the peri-incisional area. Straight leg raise was negative. There was full strength of the lower extremities. The provider's assessment was lumbar radiculitis, painful lumbar instrumentation, and residual low back pain. On 3/22/12, the patient reported pain to the neck, low back, and right shoulder. Physical examination revealed limited range of motion of the neck, with stiffness and rigidity. The provider's assessment was chronic pain of the neck, low back, and right shoulder. She was prescribed Cymbalta, Voltaren, Suboxone, and Topamax. On 4/20/12, the patient underwent exploration of lumbar fusion with removal of posterior instrumentation. On 7/11/12, the patient reported increased pain in the low back, right buttock, and right leg. She denied numbness or tingling. Physical examination revealed tenderness in the right buttock area. The incision was healed and non-tender. Straight leg raise was negative bilaterally. There was full strength throughout. The deep tendon reflexes were 1+ and symmetric. The provider's assessment was lower extremity pain status post L4 to S1 instrumentation removal. An MRI of the lumbar spine was recommended.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested diagnostic procedure. Specifically, the URA's initial denial indicated that ODG criteria indicate that MRI evaluations should be reserved for patients with a significant change in symptoms and/or findings suggestive of significant pathology, such as tumor, infection, fracture, or recurrent disc herniation. Per the URA, the medical documentation did not indicate any neurologic deficit. On appeal, the URA indicated that it is necessary to have a diagnosis based on a thorough evaluation of the symptoms and a detailed physical and neurological examination. Per the URA, the diagnosis listed only states back pain, and no specific diagnosis based on clinical examination is noted.

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

In this patient's case, the submitted documentation fails to demonstrate the medical necessity of the requested diagnostic procedure. Current evidence-based guidelines do not support the requested MRI of the lumbar spine, with and without contrast, in this clinical setting. Official Disability Guidelines (ODG) criteria do not recommend evaluation with an MRI unless there is a significant change in subjective and/or objective clinical findings. In this case, the medical documentation does not provide updated clinical evidence of progressively worse neurological deficits in the lower extremities that would suggest significant changes in the patient's

pathology. All told, the patient does not meet ODG criteria for the requested MRI of the lumbar spine, with and without contrast.

Therefore, I have determined the requested MRI of the lumbar, with and without contrast, is not medically necessary for evaluation of the patient's medical condition.

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 JUDGMENT, 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)