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Notice of Independent Review Decision

DATE OF REVIEW: April 28, 2008

IRO CASE #:

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

This case was reviewed by a Pain Management doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o June 13, 2007 through March 27, 2008 chart notes and reports
- o December 4, 2007 report by, M.D.
- o February 14, 2008 narrative report by, D.O.
- o June 13, 2007 lumbar spine x-ray report by, M.D.
- o May 14, 2007 MRI report by, M.D.
- o November 20, 2007 and December 5, 2007 narrative reports by, M.D.
- o Undated employees report of injury signed by
- o October 1, 2007 letter
- o Undated letter signed by
- o March 20, 2008 utilization review report from
- o April 10, 2008 utilization review report from

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient is a xx year-old female who sustained an industrial injury on xx/xx/xx involving the lumbar spine. The records contain a March 20, 2008 utilization review report which lists a diagnosis of degeneration of lumbar or lumbosacral intervertebral disc. According to the report, a May 2007 MRI notes an L5-S1 diskal bulge with foraminal narrowing. There was no electrical study available for review. The patient had not responded to prior conservative care including injections. She was told that surgery would not improve her condition. Neurological examination was negative in addition to the straight leg raises. The Official Disability Guidelines and the ACOEM guidelines were quoted in the report and a non-certification was rendered for an MRI as there was no electrical study and neurologic exam were essentially negative.

The patient submitted a letter which states that she would like to get the MRI approved so that she can have surgery on her back. She will not be able to have the surgery unless she has a current MRI. She feels that surgery would help pain down the right leg. She stated that the treating doctor did not say that surgery would not help at all. She advised the reviewer to look at her doctor's

report.

The case was reviewed again on April 10, 2008 and another non-certification was rendered. The report states that the patient comments were carefully considered. However, the case does not meet evidence-based criteria for a repeat MRI, as especially the December 13 notes indicate that there is no change in neurologic symptoms. The problem according to this reviewer was that the MRI is so sensitive, it could pick up changes that are of no clinical significance that would prompt a needless surgery, placing the patient at a needed risk.

The records include a June 13, 2007 lumbar spine x-ray report which showed a mildly narrowed disc space at the L4-5 level with no other significant findings. A May 14, 2007 lumbar spine MRI report includes an impression as follows: Interval development of a moderate right paracentral/lateral recess and foraminal disc protrusion at L4-5 superimposed on multifactorial canal and bilateral foraminal stenosis; mild diffuse annular bulge again identified at L2-3; and interval development of a mild annular bulge at L5-S1 associated with mild bilateral foraminal narrowing.

The records include chart notes and reports June 13, 2007 through March 27, 2008 chart notes and reports from the same clinic. The patient was initially evaluated and placed on light duty, provided medications, and referred to physical medicine and rehabilitation. A note from June 26, 2007 states that the patient wanted to get back to work as quickly as possible and wanted a surgical referral. She did not have any interest in conservative treatment. As of July 11, 2007 she reported that she had no conservative therapy. A strong recommendation was made by the neurosurgeon for conservative management to include physical therapy and possible epidural injections. She underwent an L4-5 epidural steroid injection and bilateral sacroiliac joint injections on September 26, 2007. An October 19, 2007 report states that the patient had three epidural steroid injections with no significant improvement. A November 16, 2007 report states that the patient was treated with physical therapy, anti-inflammatory medication, exercise program, and epidural steroid injections with no significant improvement. She was scheduled for a designated doctor evaluation on November 20, 2007.

She was seen by the designated doctor on November 20, 2007. Relevant examination findings included straight leg raise in seated position 90 degrees, positive on the right and negative on the left, straight leg raise in supine position positive at 30 degrees on the right with buttocks pain and 20 degrees on the left with buttocks and low back pain, positive bilateral Braggard's test, hypersensitivity to pinprick and light touch testing, symmetric ankle jerks, 2+ knee jerk on the left and 3+ on the right, mildly decreased range of motion, symmetric lower extremity motor strength, and one out of eight positive Waddell's tests. The physician stated that the length and frequency of treatment were appropriate. He further stated that based on the examination, MRI findings, and the lack of response to conservative measures, the patient is a candidate for decompression, laminectomy, and discectomy at L4-5 without fusion since almost none of her pain is in the right buttock and right leg.

Neurologic evaluation on December 13, 2007 was intact. A repeat MRI study was ordered. Notes from March 26, 2008 indicate that the patient does not wish to pursue an EMG/NCV that she does not wish the addit discomfort.

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

According to the Official Disability Guidelines, repeat MRI's are indicated only if there has been progression of neurologic deficit. The medical records fail to establish that there has been progression of a neurologic deficit. In fact, the records do not document that the patient unequivocally demonstrates a neurologic deficit due to lumbar nerve root compromise. The records fail to document clinical signs consistent with a focal neurologic deficit in a dermatomal or myotomal pattern to cause concern for current, active radiculopathy and/or progressive neurologic deficit. She did demonstrate a positive supine straight leg raise, but this was not reproduced in the seated position as she was able to extend to 90 degrees upon the designated doctor examination of November 20, 2007. In addition, the records do not demonstrate electrodiagnostic evidence of a progressive deficit, nor do they demonstrate decreased deep tendon reflexes or sensation. Given these factors, I recommend to uphold the previous determinations to non-certify the request for an MRI.

The IRO's decision is consistent with the following guidelines:

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

__X__ 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

Official Disability Guidelines (2008):

MRI's (magnetic resonance imaging)

Recommended for indications below. MRI's are test of choice for patients with prior back surgery. Repeat MRI's are indicated only if there has been progression of neurologic deficit. (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004)

(Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. The ease with which the study depicts expansion and compression of the spinal cord in the myelopathic patient may lead to false positive examinations and inappropriately aggressive therapy if findings are interpreted incorrectly. (Seidenwurm, 2000) There is controversy over whether they result in higher costs compared to X-rays including all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003) In addition, the sensitivities of the only significant MRI parameters, disc height narrowing and anular tears, are poor, and these findings alone are of limited clinical importance.

(Videman, 2003) Imaging studies are used most practically as confirmation studies once a working diagnosis is determined. MRI, although excellent at defining tumor, infection, and nerve compression, can be too sensitive with regard to degenerative disease findings and commonly displays pathology that is not responsible for the patient's symptoms. With low back pain, clinical judgment begins and ends with an understanding of a patient's life and circumstances as much as with their specific spinal pathology. (Carragee, 2004) Diagnostic imaging of the spine is associated with a high rate of abnormal findings in asymptomatic individuals. Herniated disk is found on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging disks, in 20% to 81%; and degenerative disks, in 46% to 93%. (Kinkade, 2007) Baseline MRI findings do not predict future low back pain. (Borenstein, 2001) MRI findings may be preexisting. Many MRI findings (loss of disc signal, facet arthrosis, and end plate signal changes) may represent progressive age changes not associated with acute events. (Carragee, 2006) MRI abnormalities do not predict poor outcomes after conservative care for chronic low back pain patients. (Kleinstück, 2006) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as magnetic resonance imaging (MRI) without a clear rationale for doing so. (Shekelle, 2008) There is support for MRI, depending on symptoms and signs, to rule out serious pathology such as tumor, infection, fracture, and cauda equina syndrome. Patients with severe or progressive neurologic deficits from lumbar disc herniation, or subjects with lumbar radiculopathy who do not respond to initial appropriate conservative care, are also candidates for lumbar MRI to evaluate potential for spinal interventions including injections or surgery. See also ACR Appropriateness Criteria™. See also Standing MRI.

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
- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)
- 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