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Notice of Independent Review Decision

DATE OF REVIEW: July 22, 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 an Orthopedic Surgeon, 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

Repeat lumbar MRI with and without

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

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- June 13, 2008 utilization review report by , D.O.
- May 21, 2008 utilization review report by , M.D.
- June 6, 2006 through May 9, 2008 chart notes from Orthopedic Center
- March 16, 2006 CT scan of the lumbar spine report by , M.D.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained an industrial injury on XX/XX/XX involving the lumbar spine. The request for a repeat lumbar MRI was non-certified on May 21, 2008. The reason provided was that the last clinic note submitted was dated February 2008 and there was no mention of a repeat MRI or documentation of progression of neurological deficits.

The case was again reviewed on June 13, 2008 and another non-certification rendered. The utilization review report states that the records reflect the claimant has lumbar pain and has been treated conservatively with medication, but her pain continued. She underwent surgery in June 2005 including lumbar fusion. The postoperative MRI from July 2005 revealed postoperative changes from L4 through S1. A CT scan of the lumbar spine from March 2006 revealed postoperative changes from L4 through S1. The reviewer commented that the clinician has failed to demonstrate the presence of radiculopathy, instability, or nerve root compression.

The records contain a March 16, 2006 lumbar spine CT scan report. The impression was post-surgical changes at L4-5 and L5-S1 levels. There was evidence of discectomy and anterior fusion by means of screws at L4-5. The screws were in good position. There was no solid osseous fusion of the vertebral bodies. At L5-S1, two metallic spacers (cages) were noted in good position. Although there was degradation of the images due to streak artifact from the hardware, there appeared to be solid bony fusion of the vertebral bodies at that level. Small osteophytes and facet hypertrophy reportedly resulted in stenosis of the lateral recesses at L5-S1.

The patient was seen in August 2006 with complaints of mild to moderate pain radiating to the left leg, including numbness and weakness. She was found to be neurologically intact. She was treated with physical therapy and medications. In November 2006, physical examination did not reveal positive neurological findings. On June 15, 2007, she reported for a follow-up visit and continued to complain of low back pain. She had not been able to return gainful employment due to significant complaints of discomfort. Conservative management continued. She was again seen in September 2007 and no motor function deficits were noted in the lower extremity. Medications were continued at that time. She reported for a follow-up visit on January 25, 2008. Examination revealed irritation on the left leg. Straight leg test caused reproducible leg pain and mild back pain. Motor function appeared to be otherwise intact along with sensation. X-rays revealed that the fixation had held well. There was a mild scoliosis noted at L1 to S1, but she had a solid fusion. She was again evaluated on February 29, 2008. No motor function deficits were noted in the lower extremities.

She was most recently evaluated on May 9, 2008 with complaints of pain and discomfort in her back and left leg. It was noted to be an off and on problem. Examination findings included negative straight leg raise bilaterally, intact motor function, decreased sensation, and a lot of reproducible back pain. The report states that the patient had a solid fusion anteriorly in the past. The physician considered the possibility of pseudoarthrosis or steroid related complications as the patient has evidence of epidural fibrosis. The physician recommended an MRI of the lumbar spine.

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

According to the medical records, the patient has had x-rays as recently as January 25, 2008 that demonstrated a solid fusion. Throughout the majority of the postoperative follow-up visits, the patient has been neurologically intact. The most recent evaluation notes decreased sensation, however, the records fail to document the location of this decreased sensation and whether it follows a dermatomal pattern. The physician stated that there is a possibility of pseudoarthrosis, steroid related complications, and epidural fibrosis, although documentation of supporting information for these suspicions was not provided. As noted below, the Official Disability Guidelines state that MRIs are the test of choice for patients with prior back surgery. Repeat MRIs are indicated only if there has been progression of neurologic deficit. Given that the patient has been neurologically intact throughout with the possible exception of decreased sensation in an unknown distribution, the records fail to establish that there has been progression of neurologic deficit. Therefore, my determination is to uphold the previous decisions to non-certify the request for "repeat lumbar MRI with and without."

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)/Lumbar Chapter:
MRI:
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 controversary 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