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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 06/10/08 **AMENDED:** 6-11-08

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 Orthopaedic Surgery, 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 of the lumbar spine without contrast

REVIEW OUTCOME

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

Overturned (Disagree)

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 April 18, 2008 Physicians Injury report from Dr
- o April 18 – April 22, 2008 Treatment notes, Dr
- o April 22, 2008 Work Status report
- o April 30, 2008 Office Visits notes, Dr.
- o May 1, 2008 Letter informing first denial for request for MRI
- o May 1, 2008 Review and rationale for initial denial of request for lumbar MRI
- o May 6, 2008 Nerve Conduction Study,
- o May 8, 2008 Letter informing denial for reconsideration for lumbar MRI
- o May 8, 2008 Review and rationale for denial of reconsideration for Lumbar MRI
- o May 21, 2008 Progress Notes from Dr
- o May 30, 2008 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews, the patient is a xx-year-old who sustained an industrial injury to the right knee and lumbosacral spine on xx/xx/xx when he slipped on mud and fell out of his truck. He hit his right knee and twisted. The patient was initially evaluated on the same day for edema and significant pain to the right knee. He was limping and his leg felt numb and tingly. There was low back pain upon standing. He was advised to use ice and elevate the knee and return in 3 days if there was no improvement.

Per handwritten treatment notes between xx/xx to April 22, 2008, the patient called the clinic 3 days later reporting severe low back pain. His knee was better. Vicodin was not helping the low back pain. The patient was referred to an orthopedic provider for

low back and lower extremity pain.

On April 30, 2008 the provider submitted an update with request for MRI. The patient is presently using Flexeril and Hydrocodone. He smokes a pack of cigarettes daily. On examination, he demonstrates tenderness to palpation in the lumbar region more on the right. He has a positive straight leg raising supine and sitting. His lower extremity strength is slightly diminished due pain. Reflexes are normal. Plain films did not show any acute pathology. He has acute back pain with right leg radiculopathy and probably a herniated disc. Recommendation is for lumbar MRI.

Request for lumbar MRI was not certified in review on May 1, 2008 with rationale that the medical records fail to include a current physician's report with clinical examination findings and treatment notes to support the rationale for the request. There was insufficient information to determine the medical necessity. A peer-to-peer discussion was attempted but not realized.

Nerve conduction studies performed May 6, 2008 were interpreted as showing no neuropathy in relation to plexopathy, polyneuropathy, mononeuropathy and/or primary muscle disease.

Request for reconsideration for lumbar MRI without contrast was not certified in review on May 8, 2008 with rationale that the patient did not meet the criteria of ODG to be a candidate for MRI such as failure of at least one month of conservative care. The patient is 12 days post injury and no conservative care has been documented. The neurological examination does not contain unequivocal evidence of radiculopathy.

The patient was reevaluated orthopedically on May 21, 2008. EMG/NCV studies were normal and MRI was denied. The provider's notes state the reviewer's questions are all answered in the progress notes. The patient continues with severe with flexion and extension. He has a positive straight leg raising. He has normal reflexes. He has pain with lateral bending and rotation. His motor and sensory functions are normal. MRI is requested based on his symptoms of radicular pain down his legs as well as lack of resolution of his symptoms since April 18, 2008.

The provider's handwritten notes of May 29, 2008 state, we have not heard back from peer-to-peer. Update given to adjuster. We have not heard from the UR department.

On May 30, 2008 the provider requested an IRO.

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

This patient is now over 6 weeks from the date of injury with persistent radicular symptoms with positive straight leg raise. A positive straight leg raise suggests radiculopathy. I would disagree with denial and recommend the MRI be approved as appropriate.

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

The Official Disability Guidelines – MRI Lumbar spine – 5/20/2008:

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 AHCPA 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

