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Notice of Independent Review Decision

DATE OF REVIEW: 10/22/08

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Repeat Lumbar MRI at South Texas Radiology

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

PATIENT CLINICAL HISTORY (SUMMARY):

The employee was a male who reported being involved in a motor vehicle accident where he was struck by a drunk driver while at a stop sign on xx/xx/xx. On that date, the employee was broad sided. He reported losing consciousness and did not remember the mechanism of action.

The first available medical record was dated xx/xx/xx. At that time, the employee was complaining of severe back and neck pain. He had no numbness, no radiation, and no bowel or bladder incontinence. The employee had no ongoing medical problems. On physical examination, the employee appeared to be 6 feet tall and weighed 305 pounds. His body mass index was 41.36. He was reported to be in acute discomfort. He had loss of cervical lordosis. There were muscular spasms, point tenderness, and decreased range of motion over the entire cervical spine. He had point tenderness, parathoracic muscular spasm involving the left and right thoracic spine. The lumbar spine was diffusely tender. There was paralumbar muscular tenderness. The employee had full range of motion of the lower extremities. Deep tendon reflexes were normal and equally reactive. There were no gross sensory or motor deficits. The employee was diagnosed with sprains of the neck, back, and lumbar region, and a concussion with brief loss of consciousness. The employee was provided oral medications.

The employee was referred for MRI of the lumbar spine on 07/11/08. This study

reported normal alignment of lumbar spine with no evidence of spondylolisthesis or retrolisthesis. The lumbar vertebra revealed no compression fracture or marrow replacement. The posterior elements were intact revealing no spondylolysis. There was no evidence of focal disc herniation, foraminal encroachment, or nerve root impingement.

The employee was seen in follow-up by Dr. on 07/21/08. At that time, the injured employee reported improvement but continued to experience low back pain and wanted a second opinion. Upon examination, the employee was reported to be 5 feet 11.5 inches in height and weighed 305 pounds. Upon examination of the cervical spine, there was no abnormal curvature and there was no tenderness. He had full range of motion. Examination of the thoracic spine revealed no abnormal curvatures and no point tenderness. Examination of the lumbar spine revealed no abnormal curvatures and no point tenderness. Reassurance was provided to the employee, and he was anticipated to return to work duty in seven to ten days. He was to finish physical therapy.

The employee was seen in follow-up on 08/11/08. The employee reported persistent soreness to the lower back and neck; however, there was significant improvement. He had no numbness or tingling, bowel dysfunction, or bladder dysfunction. Physical examination was unremarkable. The employee was returned to light duty.

The employee sought care from Dr. on 08/25/08.

On the same date the employee underwent radiographs of both the lumbar and thoracic spine. The lumbar report indicated mild lumbar curvature with mild spondylosis. There was evidence of very slight instability at L4-L5. Flexion and extension were reported to demonstrate a slight 2.0 mm retrolisthesis of L4 on L5 and extension reduced flexion. Radiographs of the thoracic spine revealed a focal thoracic curvature concave and to the left with Cobb angle of 12 degrees. No developmental anomalies were seen. There was mild multilevel spondylosis changes with mild disc space narrowing. There was no specific evidence of a compression fracture.

On 08/25/08, the employee was seen by Dr. The employee was reported to have back pain which appeared to be more in the thoracic area off to the left side of his back, more likely around the T10-T12 area. The employee had previously undergone an MRI which was of moderate to poor quality. Dr. opined that the study looked normal. He reported a bit of Schmorl's nodes at the T12-L1, and that there may be some degenerative changes above that. Dr. recommended a repeat MRI to focus on the thoracolumbar junction. He reported that the employee was improving but reported that a clear diagnosis was not evident. The employee's physical examination was unchanged. There was some questionable tenderness very mild out about T10 to T12, just off the left side of the spine.

The records were forwarded for a utilization review on 08/28/08. The reviewing physician non-certified the request. He reported the last MRI was on 07/11/08. There were no disc herniations and noted that the records indicated that the employee was improving. There were no neurological deficits, and therefore, an MRI was not indicated.

This result was appealed, and the case was subsequently reviewed on 09/11/08. This case was evaluated by Dr. who opined that there was no reason to repeat the imaging studies. He noted that the employee was making improvement with conservative care.

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

The request for a repeat MRI of the lumbar spine is not considered medically necessary. The available medical records indicate that the employee was involved in a T-bone motor vehicle accident on xx/xx/xx. The employee has been treated conservatively with oral medications and physical therapy and is noted to have improved. The employee was previously referred for MRI of the lumbar spine, which was performed on 07/11/08. This report indicated that there was no acute injury, no evidence of focal disc herniation, or foraminal encroachment or canal stenosis. The employee has continued to improve in physical therapy. The employee was seen by Dr. and was noted to have an essentially normal examination. Radiographs of the lumbar spine indicated a possible 2.0 mm retrolisthesis at L4 on L5. Radiographs of the thoracic spine reported focal thoracic curvature and minimal spondylosis.

Therefore, there would be no indication based on the submitted clinical records for repeat imaging study. Current evidence-based guidelines allow for repeat imaging when there is clear evidence of a progressive neurologic deficit requiring evaluation.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

The *Official Disability Guidelines*, 11th Edition, The Work Loss Data Institute.

MRIs (magnetic resonance imaging)	Recommended for indications below. MRIs are test of choice for patients with prior back surgery. Repeat MRIs are indicated only if there has been progression of neurologic deficit. (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen,
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[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 annular 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)

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| | <ul style="list-style-type: none">- 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 |
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