



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Notice of Independent Review Decision-WC

**DATE OF REVIEW: 12-14-09**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

MRI of the thoracic spine and lumbar spine

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

**REVIEW OUTCOME**

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

- Upheld (Agree)  
 Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- 8-28-09 X-rays of the thoracic spine.
- 9-3-09 MD., office visit.
- 10-9-09 MD., office visit.
- 10-9-09 MD., performed a Utilization Review. .
- 10-30-09 office visit at.
- 11-5-09 MD., performed a Utilization Review.
- 11-11-09 office visit at .

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

X-rays of the thoracic spine dated 8-28-09 shows spondylosis of thoracic spine from T6 through T10 with no fractures or dislocations.

On 9-3-09, the claimant was evaluated by MD., the claimant injured her lower back at work on. The claimant was working in the xxxx. She twisted her lower back while using the waxing machine. She felt severe low back pain. She had intermittent radiating of pain down her lower extremities into both feet. She was seen at xxx. She was released to work with restrictions. She reported she had to do her work without help. Her job was not following her work restrictions, which made her pain worse. On exam, the claimant was in severe distress. She had mild diffuse tenderness in the neck and thoracic spine. The claimant has severe diffuse tenderness in the lumbar spine bilaterally. The claimant had limited range of motion in all directions. Neurological exam shows DTR are 2+ bilaterally in the patella and Achilles. SLR is positive at 60 degrees bilaterally. X-rays of the lumbar spine showed disc space narrowing. The claimant was taken off work for two weeks. The claimant could not tolerate Naproxen and Ultram due to side effects. She was provided with Motrin and Xanax for pain and spasms.

On 10-9-09, the claimant was seen at by MD. The claimant reported that during physical therapy she heard a "crunch" which caused severe pain in the back. The claimant's medications include Xanax and Mobic. MRI of the thoracic and lumbar spine

has been denied. The claimant was given a new prescription for Darvocet. The evaluator reported that the claimant went back to work on light duty on 10-5-09. Since then she has had increased pain in her back radiating down both legs with numbness worse on the left leg. Numbness radiates to the left second, third and fourth toes. There is less numbness on the right, also second, third and fourth toes. Treadmill made her pain worse. The claimant wants to quit therapy. She will stop the treadmill.

On 10-9-09, MD., performed a Utilization Review. The evaluator reported he spoke with Dr. on 10-8-09. He reviewed the most recent clinical notes and verified that there are no radicular symptoms and no objective neurological findings. He stated that the claimant has a lot of subjective complaints. X-rays show degenerative findings, no evidence of any red flags. Recommended adverse determination. There are no red flags for serious pathology and no objective evidence of any neurological deficits. The request is not justified with the information provided.

On 10-30-09, the claimant was seen at. The claimant reports back pain. The claimant is released to return to work at light duty.

On 11-5-09, MD., performed a Utilization Review. It was his opinion that the claimant is reporting subjective thoracolumbar regional pain, no focal neurological deficits, no objective range of motion loss is noted. No report regarding the use of a home exercise program.

On 11-11-09, the claimant was seen at. The claimant reports she still has side pain. Slight touch on the side or back provokes extreme pain. The claimant is released to work at light duty.

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

DOCUMENTATION NOTES A CLAIMANT WITH COMPLAINTS OF SEVERE LOW BACK PAIN WITH RADIATION TO THE LOWER EXTREMITIES. THE CLAIMANT HAS BEEN TREATED WITH MEDICATIONS AND PHYSICAL THERAPY, WITHOUT IMPROVEMENT. THE CLAIMANT HAS POSITIVE NEUROLOGICAL SIGNS SUCH AS POSITIVE SLR AND NUMBNESS IN THE TOES. THE PAIN HAS BEEN ONGOING FOR SEVERAL MONTHS. ACCORDING TO ODG, MRI IS INDICATED IF THERE HAS BEEN PROGRESSION OF NEUROLOGIC DEFICITS. BASED ON THE DOCUMENTATION PROVIDED, AN MRI IS THE DIAGNOSTIC OF CHOICE. THEREFORE, THE REQUESTED MRI OF THE THORACIC AND LUMBAR SPINE IS CONSIDERED MEDICALLY NECESSARY.

**ODG-TWC, last update 12-3-09 Occupational Disorders of the Low Back – 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 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 AHCP 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](#)) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. ([Chou-Lancet, 2009](#)) Despite guidelines recommending parsimonious imaging, use of lumbar MRI increased by 307% during a recent 12-year interval. When judged against guidelines, one-third to two-thirds of spinal computed tomography imaging and MRI may be inappropriate. ([Deyo, 2009](#)) As an alternative to MRI, a pain assessment tool named Standardized Evaluation of Pain (StEP), with six interview questions and ten physical tests, identified patients with radicular pain with high sensitivity (92%) and specificity (97%). The diagnostic accuracy of StEP exceeded that of a dedicated screening tool for neuropathic pain and spinal magnetic resonance imaging. ([Scholz, 2009](#)) Clinical quality-based incentives are associated with less advanced imaging, whereas satisfaction measures are associated with more rapid and advanced imaging, leading Richard Deyo, in the Archives of Internal Medicine to call the fascination with lumbar spine imaging an idolatry. ([Pham, 2009](#)) 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, other “red flags”
- 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

**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
- 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)