

Notice of Independent Review Decision

DATE OF REVIEW:

01/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI lumbar spine without contrast.

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

Doctor of Osteopathy, Board Certified Anesthesiologist, Specializing in Pain Management.

REVIEW OUTCOME

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

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.

MRI of the lumbar spine without contrast is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 01/09/09 MCMC Referral
- 01/09/09 report from Management
- 01/08/09 Notice Of Assignment Of Independent Review Organization, DWC
- 01/08/09 Notice To LLC Of Case Assignment, DWC
- 01/08/09 Confirmation Of Receipt Of A Request For A Review, DWC
- 01/07/09 Request For A Review By An Independent Review Organization
- 12/01/08 letter from Management
- 12/01/08 Pre-Authorization Decision and Rationale, Management
- 11/25/08 memo from Claims Adjuster, with memo from, RN dated 11/24/08
- 11/24/08 memo from, Case Management Nurse
- 11/19/08 chart note, Management
- 11/18/08 referral form, Orthopedic Surgery Group
- 11/03/08 letter from Management
- 11/03/08 Pre-Authorization Decision and Rationale, Management
- 10/31/08 memo regarding non-authorization of repeat lumbar MRI, M.D, with memo dated 10/30/08 from RN

- 10/28/08 chart note, Management
- 10/28/08 referral form, Orthopedic Surgery Group
- 10/15/08 Certificate of Medical Necessity, Orthopedic Surgery Group
- 11/12/08, 10/15/08 evaluation reports, M.D., Orthopedic Surgery Group
- 07/24/08, 06/19/08 Follow Up notes, D.O.
- 10/15/08, 07/24/08, 06/19/08 Work Status Reports, DWC
- 07/15/08 Orthopedic Evaluation, M.D.
- 06/10/08 Group Note, PTA, Injury Clinic
- 06/03 to 06/10/08 Work Hardening Daily Flow Sheet
- 05/16/08 Report of Medical Evaluation, M.D., Evaluation Centers, with attached Review of Medical History & Physical Examination
- 01/11/08 MRI lumbar spine, M.D.
- Undated template for IRO Decision instructions, DWC
- Undated summaries of medical history,
- Undated Reports of Medical Evaluation (10/15/08, 07/15/08 Dates of Certification), DWC
- ODG Guidelines entitled, "Indications for imaging – Magnetic resonance imaging"

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a xx year old female with date of injury xx/xx/xx. The MRI showed herniation of nucleus pulposus (HNP) right L5/S1. The electromyogram (EMG) showed a right L5 radiculopathy. The injured individual has complained of right leg pain and has had positive right leg radicular findings with her prior physician, two independent medical exams (IMEs), and now her new attending provider (AP). The epidural steroid injections (ESIs) were denied although the injured individual did perform work hardening. Her new AP is now requesting a new MRI.

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

The injured individual had an MRI and EMG that showed corroborating findings. She has a physical exam (PE) that also corroborates with these tests. Two IMEs suggested ESIs and possibly surgery but this has not been done. She moved and saw a new AP in 10/2008 who suggested a new MRI due to an exacerbation in complaints. However, the injured individual's PE is similar to all the prior PEs; there are no new neurological findings nor is it clear how a new MRI would change the treatment plan of ESIs as suggested by her first AP and two IMEs.

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 2004 pg 303-304.

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES:

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



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- Myelopathy, infectious disease patient
- Myelopathy, oncology patient