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Notice of Independent Review Decision

DATE OF REVIEW: 07/17/09

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 Pain Management (Board Certified), 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

Lumbar MRI and bilateral lower extremity EMG/NCV

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 01-24-2007 Lumbar x-rays read by Dr.
- o 03-08-2007 AP-Lateral chest films read by Dr.
- o 03-12-2007 Lumbar re-exploration procedure report from Dr.
- o 03-12-2007 Intra-operative fluorosocpy report
- o 03-13-2007 X-ray report read by Dr.
- o 03-22-2007 Medical report from RN
- o 04-12-2007 Medical report from Dr.
- o 04-12-2007 Radiology report read by Dr.
- o 07-12-2007 Medical report from Dr.
- o 07-17-2007 Radiology report read by Dr.
- o 01-14-2008 Radiology report read by Dr.
- o 02-14-2008 Medical report from PA-C
- o 02-14-2008 Radiology report read by PA-C
- o 04-01-2008 Lumbar MRI report read by Dr.
- o 04-15-2008 Medical report from Dr.
- o 06-17-2008 Medical report from PA-C
- o 03-12-2009 Radiology report read by Dr.
- o 03-13-2009 Medical report from Dr.
- o 06-12-2009 Medical report from PA-C

- o 06-16-2009 Treatment request from PA-C
- o 06-19-2009 Non-determination report
- o 06-22-2009 Notice of Denial of Pre-Authorization
- o 06-29-2009 Appeal for lumbar MRI and BLE EMG from Spine Center
- o 07-02-2009 Notice of reconsideration
- o 07-06-2009 request for IRO from
- o 07-09-2009 Confirmation of receipt of request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female who has a history of chronic low back pain arising from a compensable injury of xx/xx/xx. The patient underwent lumbar laminectomy in 1998. On March 12, 2007 she was taken to surgery where lumbar re-exploration with decompressive laminectomy of the L3 and L4, posterior lumbar interbody fusion L3-4 and L4-5 using Synthes PR spacer bone grafts and laminar bone, Click'X instrumentation L3-5 and lateral mass fusion L3-4 using laminar bone and platelet gel was performed. Intra-operative x-rays showed prosthetic discs at L3-4 and L4-5, laminectomy defects and good vertebral body alignment. The patient was discharged on March 16, 2007 with prescriptions for OxyContin, Bactrim DS and Robaxin.

The patient was checked post-op on March 22, 2007 at which time the surgical staples were removed. The patient was instructed in use of the bone growth stimulator.

At reevaluation on April 12, 2007 the patient was doing well with a well-healed wound and good positioning of the grafts seen on x-rays. The patient is ready to initiate an exercise program.

On July 12, 2007 the patient reported a burning sensation in her LEFT leg, improved with Cymbalta. X-rays show good position of the grafts with no evidence of loosening. Lyrica and a spinal cord stimulator were considered for her neuritic type pain.

The patient was reevaluated post-op PLIF L3-4 and L4-5 on February 14, 2008. She reports low back pain that radiates into her buttock and RIGHT leg which goes numb with walking. She had injections which provided relief for a week. Recommendation is for lumbar MRI and follow up with pain management for consideration of injections or a spinal cord stimulator. Radiographs continue to show good placement of the instrumentation and fairly good alignment from L3-5 with interbody grafts at the L3-4 and L4-5 region.

Lumbar MRI was performed on April 1, 2008 for low back pain with pain into the LEFT leg. The conclusions state, post laminectomy changes at L3-4 and L4-5 with interbody spacers, pedicle screws, interconnecting rods spanning L3 through L5. Minimal disc bulging at T12-L1 and L5-S1 without central canal or neural foraminal narrowing. Small postsurgical fluid collection, posterior to the thecal sac at the L4 level measuring .9 cm thick x 3.3 cm craniocaudal. Left L5 screw is slightly laterally positioned but evaluation is suboptimal by MRI. If evaluation of orthopedic hardware positioning or integrity is required, a CT could be obtained.

When reevaluated on April 15, 2008 the patient reported continuing RIGHT leg pain with claudication type symptoms. Good motor strength was maintained. She is noted as obese and having gained weight and the resulting increased hyperlordosis may be irritating the relative stenosis seen at L2-3 on imaging. Consideration was given for epidural steroid injection and gastric banding for weight loss.

On May 8, 2008 the patient was provided a right transforaminal L2-3 injection which, per report of June 17, 2008, provided 80% relief for approximately one month. She reports low back pain described as pressure that increases with standing more than 10 minutes. She is 5' 3" and 241 pounds. She has good motor strength and negative straight leg raising. The MRI showed good decompression at L3-4 and L4-5, however there is some relative stenosis at L2-3 and some hyperlordosis secondary to her morbid obesity. Recommend repeat injection and gastric banding.

There is a 10- month gap in the medical records at this point.

The patient is reevaluated on March 3, 2009. She continues to have a lot of back pain. She is clearly obese and deconditioned. She is quite tender on palpation. Her symptoms appear to be emanating from stress at the level above. Facet blocks at L2-3 and repeat films are planned.

Facet blocks were administered on April 10, 2009 and on June 12, 2009 the patient reported significant improvement (80-90%) for approximately one month. She feels more benefit was obtained from the transforaminal epidural injections as they lasted longer and wore off more gradually. She reports intermittent posterior right thigh pain with prolonged sitting, standing and walking and numbness in the right toes. Her weight is 249 pounds. On examination, there is motor weakness of the right dorsiflexors, knee extensors and hip flexors. Recommendation is for lumbar MRI with and without contrast and lower extremity EMG/NCV.

Request for lumbar MRI and lower extremity EMG/NCV was not certified in review on June 19, 2009 with rationale that the medical records failed to include a comprehensive examination or a rationale of how the diagnostic study would alter the claimant's treatment plan. A peer discussion was attempted but the provider was out of town. It is noted that this reviewer notes an MRI of January 17, 2007 erroneously as January 17, 2009 and the re-exploration surgery of March 12, 2007 as March 12, 2009.

Request for reconsideration for updated MRI and lower extremity electrodiagnostic studies was not certified in review on July 2,

2009 with rationale that the injured worker is doing well with injections and there is no documentation as to why a repeat MRI or EMG/NCV are necessary. A peer discussion was attempted but the provider was not available.

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

The current MRI is dated April 1, 2008 over one year prior with findings that include small postsurgical fluid collection, posterior to the thecal sac at the L4 level measuring .9 cm thick x 3.3 cm craniocaudal and left L5 screw is slightly laterally positioned but evaluation is suboptimal by MRI. The patient has reported bilateral neuropathic type extending into the legs since soon after her surgery of March 2007. Epidural injections and facet blocks both provided temporary relief. At the examination of June 12, 2009 the provider documented motor weakness of the right dorsiflexors, knee extensors and hip flexors. A prior EMG/NCV has not been reported. Given the duration of bilateral lower extremity symptoms, the neurologic deficits documented on June 12, 2009 and the duration of time since the prior MRI, it would be reasonable to further assess any radiculopathy or neurocompressive lesion with these studies. Therefore, my recommendation is to overturn the previous non-certification for lumbar MRI and bilateral lower extremity EMG/NCV.

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
- 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

ODG: Lumbar Chapter (7-16-2009) MRIs:

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.

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. 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. 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. 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.

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%. Baseline MRI findings do not predict future low back pain. 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. MRI abnormalities do not predict poor outcomes after conservative care for chronic low back pain patients. 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. 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. 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.

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. 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.

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

The Official Disability Guidelines - Lumbar Chapter - Electromyography (7-16-2009):

Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz-Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended.

Nerve Conduction Studies:

Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious