

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** March 10, 2009

**IRO CASE #:**

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

This case was reviewed by an orthopedic surgeon, 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 without contrast

**REVIEW OUTCOME**

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

Upheld (Agree)

**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 August 24, 1998 Lumbar MRI as read by Dr.
- o December 16, 2008 Orthopedic evaluation report from Dr.
- o December 31, 2008 Pre-Authorization request form from Dr.
- o January 7, 2009 Initial review for lumbar MRI
- o January 7, 2009 Adverse determination letter for lumbar MRI
- o January 16, 2009 Letter from Dr.
- o February 2, 2009 Adverse determination letter for reconsideration, lumbar MRI
- o February 2, 2009 Handwritten letter from claimant
- o February 9, 2009 Request for IRO
- o February 25, 2009 Assignment of IRO
- o April 9, 2002 through February 12, 2009 Records from Surgeons Associates

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records submitted for review, the patient is a male employee who sustained an industrial injury to the low back on xx/xx/xx when lifting a piece of metal weighing approximately 65 pounds.

Lumbar MRI was performed on August 24, 1998 and shows mild degenerative disc disease at L3-4 and L4-5 and a small central right paramedian disc herniation at L4-5 with slight extrusion behind the superior endplate of the posterior aspect of the L5 vertebral body.

The records include April 9, 2002 through February 12, 2009 records in regard to an April 5, 2002 date of injury to his upper extremities and lower extremities, in addition to the above captioned date of injury. A June 20, 2008 progress note states that the

patient has a recurrent episode of pain in his lower back radiating to his left leg. Straight leg raise was positive. A December 3, 2002 progress note states that the patient will proceed with a lumbar epidural block to diminish his painful symptoms. However, the majority of these records are for treatment of the knees and shoulder.

An orthopedic evaluation was provided on December 16, 2008 for low back pain. The patient is currently retired. His health history is significant for high cholesterol, gastritis, early stage emphysema and bipolar disease. He is using Lortab, Soma, meloxicam, lisinopril, simvastatin and Nexium. He is 5' 11" and 175 pounds with blood pressure of 181/89. He has normal sensation and reflexes. His iliopsoas strength is 4/5 bilaterally. Dorsiflexion and plantar flexion is 5/5. The patient has requested medication of Lortab. He will need an updated MRI prior to prescribing new medication.

Request for update lumbar MRI was not certified in review on January 7, 2009 with rationale that the claimant is retired and not documented to have radiculopathy. The Official Disability Guidelines supports repeat MRI only if there is evidence of neurologic deficit. A peer-to-peer discussion was attempted but not realized.

The patient's provider has written a note requesting updated MRI for the patient to evaluate progression of his condition and need for a possible surgical intervention.

Request for reconsideration for lumbar MRI was not certified in review on February 2, 2009 with rationale that the medical records failed to document any new neurologic changes. ODG does not support repeat MRI unless there are neurologic deficits. Peer-to-peer discussion was attempted but not realized.

The patient has written a letter explaining that he quit work due his back condition and would like to undergo surgery and attempt return to work as he should be able to work another 6 years. He has quit smoking and his emphysema is early stage.

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

Per the MRI of 1998, there is mild degenerative disc disease at L3-4 and L4-5 and a small central right paramedian disc herniation at L4-5 with slight extrusion behind the superior endplate of the posterior aspect of the L5 vertebral body. The patient has retired from work due his back condition and would like to return to work if possible. He is hopeful that a surgery could resolve his back condition. He also has a bipolar diagnosis and hypertension. Per the current examination, the patient demonstrates normal sensation and reflexes. His iliopsoas strength is 4/5 bilaterally. Dorsiflexion and plantar flexion is 5/5. Iliopsoas strength is symmetrical and not, therefore a cause for concern. MRI findings would not provide a reason for a surgical intervention in a patient with benign physical examination findings. The patient does not have physical examination findings that would indicate a need or concern for surgery. ODG requires neurologic deficit such as motor weakness, abnormal sensation or abnormal reflexes, conditions not documented for this patient. A repeat MRI would not be supported by the guidelines. Therefore, my determination is to agree with the previous non-certification of the request for lumbar MRI without constraint.

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

The Official Disability Guidelines - Lumbar - Magnetic Resonance Imaging - updated February 19, 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 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) 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) 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