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DATE OF REVIEW: 05/18/09

AMENDED ON 05-26-09

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

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

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a employee who sustained an industrial injury to the back and left upper extremity on xx-xx-xx.

The patient was provided a neurological evaluation on February 24, 2009. She has left upper extremity, neck and shoulder and lower extremity complaints. She has irreversible stage 3 RSD of the left upper extremity with carpal tunnel syndrome. She complains of neck and shoulder pain and weakness in her legs with muscle spasms. She has had a pain pump removed and since then has difficulty with walking. She can't bend her legs very well and they are very sensitive to touch. Even with wearing clothes her legs get red and hot in temperatures at times and she has fallen down a lot. She has back pain radiating down her legs with a deep aching sensation with numbness and weakness reported. Coughing and sneezing do not aggravate her pain. Walking, sitting and standing aggravate her symptoms. She has muscle spasms. She has no bowel or bladder dysfunction or sexual dysfunction. She has progressive weakness and trouble walking.

On examination, her hand is very cold. She has vascular insufficiency all the way up to the axillary crease with a hypersensitive left hand. She still has 82% contraction of the elbow on the left. She has 20% flexion of her left wrist. She is not able to move her left wrist. She has 30/30 degree straight leg raising. She has distal weakness in her lower extremities. Reflexes are trace with 9 seconds of vibratory sense in the lower extremities. Impression is irreversible stage 3 of RSD of the left upper extremity, carpal tunnel syndrome bilaterally and lumbar disc radiculopathy secondary to prior placement of pain pump. Recommend, MRI of the lumbar spine to rule out recurrent disc. She has had a pain pump in the past and we think it has stimulated her problems with her back. She may need an EMG and NCV of the lower extremities and back. Continue Carbatrol 200 XR bid. Continue Phenergan 50 mg every 4 hours prn for nausea and vomiting. Continue Lyrica 75 tid. She is 100% disabled.

Request for lumbar MRI was not certified in review on February 27, 2009 with rationale that the medical records fail to document objective clinical evidence documenting initial conservative care. There is no objective clinical evidence of a progressive or severe neurological deficit. Only one physician exam was submitted for review. In the absence of additional clinical documentation, the request cannot be considered medically necessary. A peer discussion was attempted but not realized.

Request for reconsideration lumbar MRI was not certified in review on March 26, 2009 with rationale that the medical records failed to document severe or progressive neurologic deficits from lumbar disc herniation or failure of initial conservative treatments. The provider was out of town and not available for a peer discussion.

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

The patient has stage 3 RSD with significant upper extremity symptoms and lower extremity symptoms since recent removal of a pain pump. Coughing and sneezing do not aggravate her pain. She has muscle spasms and weakness and trouble walking. She has no bowel, bladder, or sexual dysfunction. Lumbar MRI is requested to rule out a recurrent disc.

According to The Official Disability Guidelines, MRI's are the test of choice for patients with prior back surgery. Repeat MRI's are indicated only if there has been progression of neurologic deficit. Indications for lumbar MRI include: Lumbar spine trauma: trauma, neurological deficit, lumbar spine trauma: seat belt (chance) fracture, 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, myelopathy.

It appears the patient has had a prior disc herniation but the patient's history is not clarified. The provider notes she may need an EMG/NCV of the lower extremities and back. It is noted that she has distal weakness, however, there is no clear radicular pattern of pain or progressive neurologic impairment. It is unclear what is indicated by distal weakness in this case. There is no sensory examination documented. The medical records fail to sufficiently clarify the patient's prior history and treatment including prior MRI studies and results. The medical records fail to document a medical necessity for the requested imaging study at this time. Therefore, my determination is to agree with the previous non-certification of the request for lumbar MRI.

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

X ____ 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 (5-11-09) 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 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 AHCPA 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) 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