I-Resolutions Inc.
An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

DATE OF REVIEW:
May/11/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Repeat MRI Thoracic Spine (72146)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

REVIEW OUTCOME:

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

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Determination Letters, 4/3/09, 4/16/09
MD, 3/25/09, 4/6/09
TDI Letter to, DO, 3/26/08
MD, 4/2/08
Dr., 5/28/08
Dr. 6/11/08
FAE, 6/23/08
IRO Summary from Carrier, 4/27/09
Dr. 10/3/07, 8/29/07
Dr., 9/25/07
Dr., 12/19/07, 4/22/08, 6/23/08, 9/23/08, 4/3/08, 4/7/08, 4/22/08
Dr., 8/26/08
Dr., 7/18/07
Dr., 7/18/07
Dr., DC, 7/26/07
Exam Abdomen, 7/18/07
Exam Lumbosacral Spine and Ribs, 7/26/07, 8/9/07
Bone Scan, 9/25/07

CT Scan Thoracic, 1/212/08
Exam Thoracic, 2/26/08
MRI Thoracic, 3/3/08
Fluoroscopic Guidance, 7/1/108
Physical Therapy, 31 visits, 8/23/07-7/29/08
Operative Report, Thoracic ESI, 7/1/08
Employers First Report of Injury or Illness, xx/xx/xx, Unsigned
Private Investigative Report, 3/19/08
Investigative Report, 11/13/08-11/19/08
Benefit Review Conference Report, 11/18/08
TDI, Decision and Order, 2/9/09
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a woman reportedly injured in xxxx when she was lifting 30 pounds and developed right rib pain. Subsequently, the pain has increased from the right side to the left, and anteriorly. This is noted by the serial examinations by the different practitioners caring for her and in her pain drawing. An MRI done 3/3/08 showed multiple level disc desiccation and mild spondlyolosis of the lower thoracic vertebrae. There was a "mild" disc protrusion posterior central at T8/9. There was no canal or foraminal stenosis or compromise by the disc. However, the radiologist commented that the "study (was) compromised due to the patient's size but still offers the information above." Dr. advised epidural injections that provided 2-3 days of relief. Dr. commented upon how her pain had expanded to include the torso from the neck to the hips, but not the upper or lower extremities. Dr. commented upon this as well. He also noted she was using a cane to get around, although she had no lower extremity symptoms. Among her other studies were xrays of the chest and ribs, a Bone Scan and a CT scan of the chest. No abnormalities were found. Records show the patient was adamant that she had a disc herniation while Dr. showed her it was a protrusion. Dr. described that SLR was giving her thoracic pain. He found no neurological loss. He felt the previous MRI was inadequate and that she had a second disc herniation or protrusion and requested a repeat MRI.

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

The MRI showed a disc protrusion that would not explain her symptoms. Records indicate that after the disc protrusion was identified, the person's symptoms increased. Symptoms were present in the left and right sided and both the anterior and posterior parts of the chest and abdomen, yet did not affect the extremities. The pain from the neck, per the pain drawings and description, would have included some of the T1 fibers down the upper extremities. There was none. There was no complaint regarding the bladder, bowel, or lower extremities. It is unclear from the records why the patient is using a cane if there are no symptoms in the lower extremities. The straight leg raising increased her thoracic pain. Records indicate SLR pulls on the lower lumbar nerve roots. wrote that excessive dural stretch that could pull higher would not be reached with the 60 degrees SLR. The records are not clear if this is limited to symptom magnification or evidence of nonorganicity of her symptoms. Even the radiologist commented upon the poor quality of the MRI of March 2008. Because the patient is obese, it is unclear if the quality would be improved with repeated studies. However, before attributing her symptoms to a functional cause, the reviewer agrees with the treating physician that it would be best to exclude an organic component of her pain. A noninvasive study could therefore be justified. The reviewer finds that medical necessity exists for Repeat MRI Thoracic Spine (72146).

MRI's (magnetic resonance imaging)

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 controversary 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) 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

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA 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

[X] 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)