

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

DATE OF REVIEW: 11/16/09

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 without contrast (72148)

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 01-13-09 Lumbar MRI as read by Dr.
- o 08-10-09 Orthopedic Examination report from Dr.
- o 09-18-09 Office Visit note from Dr.
- o 09-24-09 Faxed pre-authorization request for lumbar MRI without contrast
- o 09-29-09 Initial Adverse Determination Letter
- o 10-02-09 Follow-up report from Dr.
- o 10-05-09 Request for pre-authorization from Spine and Pain Control
- o 10-12-09 Adverse Determination Letter for Reconsideration
- o 10-22-09 Request for IRO from the provider
- o 10-28-09 Confirmation of Receipt of IRO from TDI
- o 10-29-09 Notice of Case Assignment of IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the low back on xx/xx/xx when lifting milk cartons. She was initially treated with medication and a course of physical therapy. She was released to light duty but reported increased symptoms.

Lumbar MRI was performed on February 17, 2007 and revealed at L5-S1, moderate right foraminal disc protrusion displacing the right S1 nerve root posteriorly and combining with facet arthropathy causing right foraminal stenosis.

The patient underwent an orthopedic disability evaluation on August 10, 2009. It was determined that the treatment rendered has been appropriate and related to the compensable injury. She was offered epidural injections early on and declined but currently is reconsidering injections. The patient's treatment history was summarized. Following MRI additional PT was not authorized. She

was released to full duty in June 2007. In July, the provider indicated she had declined epidural injections and was walking about 1 mile daily and had a normal neurologic exam. She was deemed MMI on June 21, 2007 with 5% impairment. She was referred to her current provider who recommended lumbar epidural injections which was not authorized. She was referred to PT but PT was not authorized.

Per the disability evaluator, she currently reports right-sided low back pain with right posterolateral thigh and leg pain and numbness of the lateral 3 toes of the right foot. She is using ibuprofen 600 mg twice daily. She has Vicodin but does not use it as it causes nausea. She uses amitriptyline 10 mg about 3 times a week. She tries to walk 30 minutes about 4 times a week. The provider's notes indicate she was released to full duty but she states in reality she is working with a 20 pound lifting restriction. She is 5' 6" and 125 pounds. Flexion causes posterolateral thigh discomfort. Reflexes are symmetrical. There is a painful numbness on the posterolateral right thigh, right leg numbness and of the lateral 3 toes of the right foot. Left straight leg raise causes right low back pain and right straight leg raise causes posterolateral leg and thigh discomfort. Lumbar epidural injections were recommended. Her medications are appropriate. She would benefit from return to light duty work.

The patient was reevaluated in pain management on September 18, 2009. She reports the epidural injection was not helpful. The pain eased for one day and then returned more severe. She reports pain of 9/10 and sleep difficulty. Reflexes are symmetrical. Motor strength is 5/5 in all major groups. Sensation is decreased in the right S1 distribution. Straight leg raise is positive on the right at 45 degrees. Diagnosis is herniated lumbar disc and lumbar radiculitis. Additional injections are not recommended. She will be referred for possible discectomy.

On September 24, 2009 request was made for lumbar MRI without contrast.

Request for lumbar MRI was considered in review on September 29, 2009 with recommendation for non-certification with rationale that the physical examination findings are consistent with the MRI findings and there has been no change in the physical examination. The pain management provider was called and indicated the request may have originated from the orthopedic provider.

The patient returned to pain management on October 2, 2009. She is pending a surgical appointment. Blood pressure is 165/87. Her pain level is 8/10. Lower extremity motor strength is symmetrical.

On October 5, 2009 request was again made for lumbar MRI without contrast.

Request for reconsideration lumbar MRI without contrast was considered in review on October 12, 2009 and recommended for non-certification with rationale that the medical report of October 2, 2009 noted low back pain but no changes were noted with the neurologic examination. The RME report of August 2009 was reviewed. ODG would not support the request as no new neurologic changes were noted.

Request has been made for an IRO.

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

Per ODG, 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. 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.

The most recent MRI of approximately 32 months prior revealed moderate right foraminal disc protrusion at L5-S1 displacing the right S1 nerve root posteriorly and combining with facet arthropathy causing some right foraminal stenosis. Clinically, in August 2009, there is a painful numbness on the posterolateral right thigh, right leg numbness and of the lateral 3 toes of the right foot. Epidural injections were recommended and an injection provided with no significant benefit. In September 2009 examination shows decreased sensation in the right S1 distribution and positive straight leg raise on the right at 45 degrees. She is being considered for possible surgical discectomy.

The patient has continuing S1 hypesthesia which corresponds with a prior MRI of approximately 32 months prior. The patient continues with pain. RME opinions recommended epidural injection which was attempted without significant benefit. The patient already meets the ODG criteria for possible discectomy with documentation of, unilateral buttock/posterior thigh/calf pain, attempt of medications, therapy and injections and imaging showing S1 nerve compression and right foraminal stenosis. However, a new MRI scan is not needed unless the patient has agreed to having the surgery. Should surgery be agreed upon, then an updated MRI scan is medically reasonable prior to scheduling surgery. In this case, the patient was reluctant to have an epidural injection, and it is unclear whether she desires to move forward with surgery at this time.

Therefore my recommendation is to agree with the previous non-certification for lumbar MRI without contrast (72148)

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 Chapter (10-30-2009) 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. (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.

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.

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

ODG - Lumbar Chapter (10-30-2009)

ODG Indications for Surgery -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

D. S1 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. MR imaging
2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- A. Activity modification (not bed rest) after patient education (>= 2 months)
- B. Drug therapy, requiring at least ONE of the following:
 1. NSAID drug therapy
 2. Other analgesic therapy
 3. Muscle relaxants
 4. Epidural Steroid Injection (ESI)
- C. Support provider referral, requiring at least ONE of the following (in order of priority):
 1. Physical therapy (teach home exercise/stretching)
 2. Manual therapy (chiropractor or massage therapist)
 3. Psychological screening that could affect surgical outcome