

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 04/23/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: MRI of the thoracic spine w/wo contrast 72157

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

Texas Board Certified Anesthesiologist/Pain Management

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Prescription for thoracic MRI with and without contrast dated 02/09/10.
2. Clinic note operative report refill dated 02/10.
3. Utilization review determination dated 02/24/10.
4. Utilization review determination dated 03/17/10.
5. Carrier correspondence.
6. Carrier submission dated 04/07/10.
7. ***Official Disability Guidelines***

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who was reported to have sustained an injury to his low back on xx/xx/xx. This would appear to be result of unloading doors when he developed low back pain. No detailed clinical records were submitted for review.

The available records consist of an operative report refill dated February, 2010 which indicated the employee had chronic lumbar pain, chronic pain syndrome, and lumbar laminectomy with fusion. His pain scores were reported to be 9/10 with pain in left hip and low back. Blood pressure is mildly elevated with systolic pressure of 94. His pulse is 72 and respirations are 16. His last urine drug screen was 09/09. He reported his pain levels with sitting or standing was 9/10. He underwent interrogation and reprogramming of Synchromed pump.

The employee was reported to have a history of lumbar surgery in 1995 and 1998. The record includes a request for MRI of thoracic spine dated 02/09/10 to rule out inflammatory mass at tip of catheter. The tip was reported to be at T10. This was recommended to be performed with contrast.

This request was initially reviewed on 02/24/10 by Dr.. Dr. noted he received a total of eight pages of clinical information. He opined that the request was not medically necessary noting that no clinic notes were submitted for review to include comprehensive physical examination. He noted it was unclear when the employee's intrathecal pump was implanted. He noted the submitted scientific literature indicates granulation of catheter tip may occur between twenty-four and twenty-seven months after implantation. He noted there was no indication that the employee had an increase in his pain rating, diminished analgesic coverage and / or progression of neurologic deficits that would indicate a possible granulation of catheter tip. Dr. recommended additional clinical documentation to be submitted to determine appropriateness of request and subsequently non-certified.

The request was reviewed on 03/17/10 by Dr.. Dr. non-certified the request noting that provider failed to include comprehensive medical history and detailed physical examination. He notes no other records that were submitted for review indicate the presence of most common symptoms noted with intrathecal catheter tip granuloma such as loss of effective pain relief, dose escalation of medicines, change in sensation, changes in proprioception, etc. He notes a clinic note from February, 2010 showed that the functionality of the employee was increased and the rate of infusion pump is even decreased. He reported at that juncture there was no indication of presence of catheter tip granuloma in records submitted to justify the request. He therefore, non-certified and noted the request does not meet current evidence-based guidelines.

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

The request for thoracic MRI with and without contrast is not supported by the submitted clinical information. The available medical record for this review consisted of clinic note dated February, 2010 and previous utilization review determinations. The previous reviewers clearly indicate there is insufficient clinical information to establish the presence of catheter tip granuloma, noting that there are no historical records or detailed physical examinations. There are no findings reported in the limited information that would indicate presence of granuloma and subsequent malfunctioning of device. As such, the previous determinations are upheld, and medical necessity for thoracic MRI with contrast is not established.

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

The 2010 *Official Disability Guidelines*, 15th Edition, The Work Loss Data Institute. Online edition.

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 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 AHCP 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](#)) Clinical quality-based incentives are associated with less advanced imaging, whereas satisfaction measures are associated with more rapid and advanced imaging, leading Richard Deyo, in the Archives of Internal Medicine to call the fascination with lumbar spine imaging an idolatry. ([Pham, 2009](#)) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the *Journal of the American College of Radiology*. There were high rates of inappropriate examinations for spinal CTs (53%), and for spinal MRIs (35%), including lumbar spine MRI for acute back pain without conservative therapy. ([Lehnert, 2010](#)) 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, other “red flags”
- 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