



CLAIMS EVAL

Utilization Review and
Peer Review Services

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 5-24-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Magnetic resonance (EG, Proton) imaging, spinal canal and contents, lumbar; without contrast material.

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

Doctor in Chiropractic Medicine

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 10-22-08 MRI of the lumbar spine.
- 2-12-09 EMG/NCS of the lower extremities performed by MD.
- 5-27-09 Mental Health Evaluation.
- MD., office visits on 6-10-09 and 9-16-09.
- 6-17-09 MD., office visit.
- 10-8-09 MD., performed a Designated Doctor Evaluation.
- 11-5-09 DC., provided a rebuttal letter.
- 12-10-09 MD., office visit.
- 4-5-10 DC., performed a Utilization Review.
- 4-28-10 DC., office visit.
- 5-6-10 DC., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

10-22-08 MRI of the lumbar spine showed there is normal alignment of the lumbar spine. No metastatic process or compression fracture is identified. Disc height is adequately maintained at each level, but there is minimal to moderate low signal change in all of the lumbar discs. There is no posterior protrusion from T9-10 to L1-2. Lateral saggital cuts at these levels do not show any encroachment on the neural foramina. There is a 3-mm disc herniation at L2-3 with 15% effacement of the thecal sac. The neural foramina at his level do not show any significant encroachment, and there is no spinal stenosis. There is no posterior protrusion at L3-4. There is a 3- to 4-mm symmetrical posterior disc herniation at L4-5 with an estimated 15% effacement of the thecal sac. The neural foramina at this level show mild encroachment. There is a 4-mm symmetrical disc herniation at L5-S1 with abutment but no effacement of the thecal sac. The neural foramina show mild encroachment inferiorly with no entrapment. The facets show minimal to moderate hypertrophic change, but there is no spinal stenosis.

EMG/NCS of the lower extremities dated 2-12-09 performed by, MD., showed L5-S1 nerve root irritation.

Mental Health Evaluation dated 5-27-09 noted the claimant manifested symptoms pattern consistent with the disorder of pain disorder associated with both psychological factors and a general medical condition. It was recommended the claimant participate in a course of psychotherapy.

Follow up visit with Dr. on 6-10-09 noted the claimant did not get long lasting pain relief from her epidural steroid injection. He noted the claimant was continued with her medications, Motrin 400 mg bid. The claimant recommended referral to Dr. for surgical consultation.

On 6-17-09, the claimant was evaluated by MD. He noted that on exam, the claimant is grossly obese. The evaluator reported that in an attempt to move forward with some treatment, the evaluator recommended aquatic therapy basically with ultrasound and e-stim. The claimant was also placed on a soft corset. The claimant was provided with a prescription for Mobic, Flexeril and Darvocet for pain. The evaluator also felt that a consultation with a bariatric surgeon regarding possibilities with her weight control was indicated.

On 9-16-09, the claimant was seen by MD. The claimant was seen for refill of her medications. On exam, the claimant has positive SLR on the left and cross SSLR. The claimant has discomfort with flexion, extension and right lateral flexion. The claimant has a slight antalgic gait. Strength is 5/5, DTR are 2+ and symmetrical at patella and 1+ and symmetrical at Achilles. There are sensory changes to light touch in L4 and S1 dermatoma in the left lower extremity. The claimant was provided with a prescription for Relafen.

On 10-8-09, MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI and awarded the claimant 5% impairment rating.

On 11-5-09, DC., provided a rebuttal of the impairment rating. He felt the claimant belonged in DRE Category III for 15%.

12-10-09, MD., the claimant has ongoing low back pain with radiation down her legs. She was started with physical therapy and epidural steroid injection and he also had nerve root blocks. She stated that both legs are involved equally. On exam, the claimant had normal strength in the iliopsoas and quadriceps. The quadriceps reflexes were normal. There was weakness in the tibialis anterior bilaterally. Ankle reflexes were depressed bilaterally. There was weakness in the gastroc and soleus group bilaterally. The evaluator recommended an updated MRI scan.

4-5-10 DC., performed a Utilization Review. It was his opinion that there was no documentation of progressive neurological deficits. Therefore, the request for MRI of the lumbar spine is not medically necessary.

On 4-28-10, DC., evaluated the claimant. He noted the claimant presents today for re-examination. The claimant continues to complain of ongoing low back pain rated 3/10 on a visual analog scale that has become constant in nature. The claimant was returned to work with light duty restrictions and her employer would not accommodate the restrictions placed on her. She has been unsuccessful to obtain work at this time. It should be reminded that a nerve block was performed under the direction of Dr. on May 18, 2009 with only temporary relief of pain. The claimant has been referred for a chronic pain management program that was denied by her insurance carrier. Repeat MRI of the lumbar spine has been requested due to worsening condition that has been denied by the carrier. The claimant has been denied a work-conditioning program to assist her with return to work issues and has been recommended to undergo simple decompression of the lumbar spine. Physical exam showed the claimant walks with slow and hesitant gait and movement patterns and presents with a (+) Minors sign when rising from a seated position. She does appear to be alert, coherent, coordinated, and oriented to person, place, time, and circumstances. The patient is severely obese. Muscle spasm and palpatory tenderness is present in the lumbar paravertebral musculatures bilateral, manual muscle testing is graded +4/5 to include the bilateral Peroneus and Extensor Hallicus Longus motor power responses. All other lower extremity motor power response testing is graded +5/5 and is unremarkable, Deep tendon reflex testing is graded +1 for the bilateral Achilles reflexes. Bilateral patellar reflexes are graded +2. Sensory assessment of the patient identifies paresthesia in the L5 and S1 dermatomes bilateral. Orthopedic assessment identifies (+) Straight Leg Raise testing bilateral elevating low back and lower extremity pain on the right that is supported by (+) Braggard's testing on the right. (+) Kemp's testing bilateral producing low back and lower extremity pain on the right. The evaluator reported the claimant is pending work conditioning program due to patient being unable to return to gainful employment with restricted duty modifications. Advised the patient to perform a home stretch and exercise program to maintain flexibility and strength.

On 5-6-10DC., performed a Utilization Review. It was his opinion that there is insufficient objective clinical evidence of progressive neurologic deficit on physical exam

to warrant this request as medically necessary at this time. There are no sensory, motor, or strength deficits documented that demonstrates evidence of a progressive neurological issue that has developed with this patient from his previous MRI study to now. It is also noted that the patient has several positive Waddell's signs on physical exam. There is also no clinical evidence of failed efforts of conservative care such as physical therapy to date. As there is insufficient objective clinical evidence of a neurological deficit or objective evidence of other "red flags" that would warrant the need for this patient to have an MRI, this request cannot be deemed medically necessary at this time. Conclusion/Decision to Not Certify.

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

Evidence-based guidelines do not support repeat MRI unless objective evidence of progressive neurological deficit is clearly shown. In this case, documentation does not demonstrate this criteria as recent findings are largely unchanged from previous examinations. The claimant's failure to progress with conservative and secondary levels of care cannot, by itself, support a request for the repeat of an imaging study that continues to be consistent with that claimant's presentation and findings. Therefore, the request for Magnetic resonance (EG, Proton) imaging, spinal canal and contents, lumbar; without contrast material is not reasonable or medically necessary.

ODG-TWC, last update 5-18-10 Occupational Disorders of the Low Back – MRI of the lumbar spine: 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 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) 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

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)