

Notice of Independent Review Decision

DATE OF REVIEW:

05/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar MRI.

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

Doctor of Osteopathy, Board Certified Anesthesiologist, Specializing in Pain Management

REVIEW OUTCOME

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

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.

Outpatient lumbar MRI is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 04/26/10 MCMC Referral
- 04/26/10 letter from Quality Assurance Team, State Office of Risk Management
- 04/26/10 Notice of Assignment of Independent Review Organization, DWC
- 04/26/10 Notice To Utilization Review Agent Of Assignment, DWC
- 04/26/10 Notice To MCMC, LLC Of Case Assignment, DWC
- 04/23/10 Confirmation Of Receipt Of A Request For A Review, DWC
- 04/18/10 Request For A Review By An Independent Review Organization
- 04/08/10, 04/21/10 Notice of Utilization Review Findings, Forte
- 04/08/10 letter from Forte
- 04/05/10, 04/14/10 (fax dates) Pre Authorization Requests For MRI, Clinic
- 04/02/10 prescription note, M.D.
- 03/16/10, 03/30/10, 04/14/10 office notes, M.D., Clinic
- 11/26/02 (date of exam) Report of Medical Evaluation, DWC
- 11/26/02 Impairment Rating report, D.C., OnSite MedTest
- 11/14/02 notice from Texas Workers' Compensation Commission
- 09/17/02 Report of Medical Evaluation, DWC
- 12/10/01 therapy Progress Report (handwritten)

- 11/08/01 to 12/19/01 Rapid Recovery Program flow sheets, Optimum Rehabilitation and Fitness
- 10/29/01, 11/28/01, 01/07/02 letters from M.D.
- 10/09/01 Employee's Report of Injury
- 08/13/01 to 10/10/01 handwritten Progress Notes
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a male who sustained a back and knee injury in xx/xxxx. He had an MRI at that time which showed a left L5/S1 herniation of nucleus pulposus (HNP) and a central L4/5 HNP. On exam then he had positive Lasegue and no left Achilles deep tendon reflex (DTR). He responded well to physical therapy (PT) and returned to work. He is now complaining of increased leg pain but his physical exam (PE) is the same as it was before. There are no new findings noted. The attending provider (AP) states he "still" has a reduced left Achilles DTR.

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

The injured individual had this test at time of injury nine years ago and it showed pathology. His PE is the same now as it was then with no acute change. There is no indication for a new MRI.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines: 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