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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 11, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI Lumbar 72148 to complete by 5-6-11

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

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

On February 7, 2011 the claimant was seen for a follow up appointment by MD, FACS. The examination states that the incision is well healed, there is some marked spasm in the lower lumbar area. Straight leg raising is negative to 90 degrees; motor strength is 5/5. The left calf is tender, Homan's test is negative. Peripheral pulses are intact, legs are warm and dry and capillary refill is brisk bilaterally. The impression states: 1. Residual lower back pain and left leg pain, status post L4-5 micro lumbar discectomy 11/5/2010; 2. Lumbar facet syndrome.

On February 17, 2011 a denial of request for Lumbar MRI was sent to MD by Corporation. The rationale states this patient had a lumbar disc excision at L4-5 by Dr. in November 2010. The patient is having back spasms but there are no objective neurological deficits noted with the motor strength at 5/5 and the straight leg raise negative. The operative report was not forwarded but there was no mention of any intraoperative complications. The necessity of a repeat MRI at this time is not validated per ODG criteria. Thus the request is not approved. REF: ODG TWC LOW BACK. Documentation reviewed : MRI 4-22-10, Office note 2-07-11 notes Peer review 2-26-10 DDF 8026-10 On 2-15-11 I called the office at 12:05 and s/w answering service-I asked for Dr/precert rep 02-15-11 call #2 at 1:15 spoke with -I asked for doctor/precert-Dr. is in surgery-put on hold for 02-15-11 call #3 at 2:10 spoke to then we discussed and he agreed to reassess patient.

On February 24, 2011 there is a letter from MD FACS which states that the claimant is under his care for an on the job injury x/xx/xxxx and claimant is status post L4-5 decompressive hemi-laminotomies and bilateral L4-5 partial medial facetectomies with lateral recess decompression and L5 nerve root decompression with L4-5 discectomy on 11/5/2010. The claimant was started on physical therapy and developed increased symptomatology with low back and left calf pain which began after the claimant heard a pop in his back. Dr. states that lumbosacral spine x-rays with flexion and extension dated 12/9/2010 was unremarkable and an MRI scan of the lumbar spine to rule out a recurrent disc herniation.

On March 14, 2011 an appeal denial of request for Lumbar MRI was sent to MD by Corporation. The rationale states: Deny Recon MRI Lumbar 72148 to complete by 5-6-11; however the complete rationale does not fit in the rationale box, complete rationale proved to requestor, claimant and doctor. Please see attached. APPEAL DENIED, THIS IS THE SECOND REQUEST AND DENIED BY A PHYSICIAN, ANY FURTHER REQUESTS SHOULD BE SUBMITTED THROUGH THE APPEAL PROCESS WITH IRO.

Conclusion: The patient is a xx-year-old male with complaint of low back pain, with a history significant for L4-5 microlumbar discectomy, Official Disability Guidelines suggest that indications for imaging for patient with low back pain and radiculopathy should be considered after at least one month's conservative therapy, however, it may be done sooner if severe or progressive neurological deficit exists. The documentation submitted for review is insufficient to evidence objective clinical finding of radiculopathy or any other red flags, which would warrant MRI. Documentation was insufficient to determine if the patient had been tried on conservative therapies and the efficacy of the treatments. As such, the request for reconsideration of MRI lumbar is not medically necessary at this time.

PATIENT CLINICAL HISTORY:

The claimant has a history of L4-5 microlumbar discectomy.

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

The previous decisions are overturned. Based on the fact the claimant started physical therapy and developed increased symptomatology such as low back and left calf pain and has had prior surgical intervention per the ODG the MRI of the Lumbar Spine is indicated.

<p>MRIs (magnetic resonance imaging)</p>	<p>Recommended for indications below. MRI's are test of choice for patients with prior back surgery. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007)</p> <p>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</p>
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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 annular 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](#)) Degenerative changes in the thoracic spine on MRI were observed in approximately half of the subjects with no symptoms in this study. ([Matsumoto, 2010](#)) This large case series concluded that iatrogenic effects of early MRI are worse disability and increased medical costs and surgery, unrelated to severity. ([Webster, 2010](#)) Routine imaging for low back pain is not beneficial and may even be harmful, according to new guidelines from the American College of Physicians. Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. ([Chou, 2011](#)) 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

	<p>potential for spinal interventions including injections or surgery. For unequivocal evidence of radiculopathy, see AMA Guides. (Andersson, 2000) See also ACR Appropriateness Criteria™. See also Standing MRI.</p> <p><u>Indications for imaging -- Magnetic resonance imaging:</u></p> <ul style="list-style-type: none"> - 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. - 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
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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 KNOWLEDGBASE
- 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)