

Notice of Independent Review Decision

**DATE OF REVIEW: 04/09/12**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

1 MRI of the Lumbar Spine without Contrast

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

**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.

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records Received: 17 page fax 03/19/12 IRO request, 68 page fax 03/20/12 URA response to disputed services including administrative and medical records. Dates of documents range from 07/12/11(DOI) to 3/19/12.

- Initial adverse determination by URA, 02/09/12
- Appeal reconsideration letter dated 03/01/12
- Lumbar MRI, 08/13/11, report indicating no acute change but multilevel degenerative disk disease.

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- 02/06/12, request by
- medical treatment records for post-shoulder surgery therapy from 11/23/11 through 01/04/12.
- Medical record review, family practice, occupational medicine, dated 02/09/12.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the above medical records, this individual was originally injured while in the process of loading 50-pound bags from a pallet onto a truck. While placing a bag over his shoulder, he tripped over a pallet with the 50-pound bag on his left shoulder and fell backwards onto his back. There was no head trauma. He experienced pain in the neck, back, and shoulder. Pain radiated from the left leg into the back region and the neck into the left shoulder. Straight leg raising was negative bilaterally. He was identified with primary injury affecting the shoulder. He underwent presurgical treatment and diagnostic studies, which included a lumbar MRI 08/13/11 indicating no acute change.

MRI of the left shoulder was performed 10/05/11. There was a nearly complete tear of the rotator cuff tendon with few intact fibers. There was impingement of the rotator cuff at the acromioclavicular joint secondary to inferiorly projecting osteophytes. Mild degenerative changes were noted at the acromioclavicular joint.

Subsequent to the failure of nonsurgical treatment, and with the abnormalities noted on MRI, the patient underwent surgical treatment to the shoulder.

The patient then received postsurgical rehabilitation. The patient has continued with lower back pain and has been denied twice on original preauthorization and on reconsideration for repeat lumbar MRI.

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

The patient did undergo an MRI study, which was performed 08/03/11, indicating the following conclusions:

1. No evidence of an acute fracture.
2. L5-S1 changes of moderate degenerative spondylosis and facet degenerative disease. Osteophytes, bulging disks, and facet hypertrophy results in narrowing of both neural foramina. The exiting nerve roots abut against the osteophyte/disk complex.
3. L4-5 changes of degenerative spondylosis, posterior disk bulge, and a small right posterolateral disk herniation. Mild to moderate degree of

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- spinal stenosis noted secondary to bulging disk, facet, and ligamentum flavum hypertrophy.
4. Changes of facet degenerative disease from L2-3 to L5-S1 levels.

There is no indication of any significant altered or objective neurologic or orthopedic change that would support a repeat lumbar MRI. The changes noted were indicated to be preexisting, ordinary disease of life, degenerative disk disease.

## ODG Repeat MRI Lumbar

MRIs (magnetic resonance imaging)	<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) 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</p>
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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) The National Physicians Alliance compiled a "top 5" list of procedures in primary care that do little if anything to improve outcomes but excel at wasting limited healthcare dollars, and the list included routinely ordering diagnostic imaging for patients with low back pain, but with no warning flags, such as severe or progressive neurologic deficits, within the first 6 weeks. (Aguilar, 2011) Owning MRI equipment is a strongly correlated with patients receiving MRI scans, and having an MRI scan increases the probability of having surgery by 34%. (Shreibati, 2011) A considerable proportion of patients may be classified incorrectly by MRI for lumbar disc herniation, or for spinal stenosis. Pooled analysis resulted in a summary estimate of sensitivity of 75% and specificity of 77% for disc herniation. (Wassenaar, 2011) (Sigmundsson, 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 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.

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.

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|  | <ul style="list-style-type: none"><li>- Uncomplicated low back pain, prior lumbar surgery</li><li>- Uncomplicated low back pain, cauda equina syndrome</li><li>- Myelopathy (neurological deficit related to the spinal cord), traumatic</li><li>- Myelopathy, painful</li><li>- Myelopathy, sudden onset</li><li>- Myelopathy, stepwise progressive</li><li>- Myelopathy, slowly progressive</li><li>- Myelopathy, infectious disease patient</li><li>- Myelopathy, oncology patient</li></ul> |
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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 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)