

# AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

**[Date notice sent to all parties]:** July 21, 2012

**IRO CASE #:**

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

Repeat Lumbar MRI

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

This physician is 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

10-06-11: MRI Lumbar Spine without Contrast at xxxx dictated by MD

11-11-11: Consultation note at xxxx, PA dictated by MD.

12-15-11: Office consultation at xxx xxx xxxx dictated by MD

02-16-12: Texas Workers' Compensation Work Status Report completed by MD

02-16-12: Roentgenographic Interpretation at xxxxe, PA dictated by MD

02-16-12: Narrative Report at xxxx, PA dictated by MD

02-22-12: Texas Workers' Compensation Work Status Report completed by MD

03-02-12: Initial Evaluation at xxxxx dictated by, PT, DPT

03-06-12: Office visit dictated by DO

03-06-12: Functional Capacity Evaluation performed by DC at xxxxx

03-06-12: Patient Report of Work Duties

03-08-12: Initial Behavioral Medicine Consultation at Injury dictated by LPC and PhD

03-08-12: Multidisciplinary Work Hardening Plan & Goals of Treatment at Injury dictated DO

03-09-12: Treatment Encounter Note at Physical Therapy dictated by PT, DPT

03-16-12: Discharge Summary at Physical Therapy dictated by, PT, DPT  
03-22-12: Office visit at xxxxx, PA dictated by MD  
03-23-12: Reconsideration: Work Hardening Program  
04-19-12: Office Visit at Microsurgery of the Spine, PA dictated by MD  
05-02-12: UR performed by xxxxx, MD  
05-17-12: Office Visit at xxxxx, PA dictated by MD  
05-31-12: UR performed by MD

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female that while working on x/xx/xx was lifting heavy trash bags and putting them in a dumpster, which she did daily, about 40 lbs. She sustained an injury with an acute onset of low back pain with radiation to bilateral lower extremities, left side greater than right, with associated numbness and tingling in a nondeterminational distribution.

01-06-11: MRI Lumbar Spine without contrast dictated by MD. Impression: 1. Small disc bulge or protrusion at T12-L1, L3-4, and L4-5. 2. No focal disc extrusion, significant central spinal stenosis, or foraminal stenosis. 3. Hemangioma at L3 without acute osseous abnormality. This is an incidental finding.

11-11-11: Consultation note dictated by MD. The claimant is status post a short course of physical therapy with no significant improvement in her symptomatology. Claimant stated her pain in her lower back to be 9/10 with worsening after prolonged sitting, standing, coughing, sneezing or Valsalva maneuver. Claimant denies bowel/bladder dysfunctions at this time. (Incomplete entry, missing second page of the report)

12-15-11: Office consultation note dictated by MD. Claimant presented with constant complaints of lower back pain 8-9/10 with limited range of motion and aggravating symptoms. Symptoms are exacerbated with sitting or standing in one position for more than 10 minutes at a time or with Valsalva maneuver. Physical Examination: Moderately restricted range of motion in lumbar flexion, extension and lateral bending by 25%. There is pain upon palpation over the facet joints at L4-L5 and L5-S1 bilaterally. The deep tendon reflexes are diminished at the left knee. The claimant can heel and toe walk with difficulty. Dr. noted the claimant's symptoms worsen in lumbar extension. There is pain with deep palpation over L4-L5 and L5-S1 facet joints bilaterally. Recommend lumbar facet joint injections at L4-L5 and L5-S1 bilaterally under fluoroscopy guidance.

02-16-12: Roentgenographic Interpretation dictated by MD. Roentgenographic Evaluation of the Lumbar Spine: Claimant's lumbar spine films reveal flattening of the lumbar lordotic curve. There is no asymmetry of the disc space. No evidence of flexion/extension instability noted. The pars interarticularis is intact. The spinous processes are midline on the AP and the SI joints are patent.

02-16-12: Narrative Report dictated by MD. Claimant's chief complaints: neck pain, back pain, bilateral leg pain and bilateral arm pain rated 9/10. The pain limits her activity, to include working, exercising and having sex. Activities that increase the pain include sitting, standing, walking, working, driving, sleeping, and lifting. Activities that decrease the pain include taking medications. Claimant has numbness present in both legs and arms and is currently undergoing physical therapy, to include heat and exercises. Physical Examination: Range of Motion: Lumbar Spine: Flexion – 50%; Extension – 50%; Right lateral flexion – 50%; Left lateral flexion – 50%; Right rotation – 50%; Left rotation – 50%. Muscle Strength: All muscle groups tested in the upper and lower extremities were grade 5 on a scale of 5. Supine Straight Leg Raising: Positive bilaterally. Hamstring length is 60 degrees bilaterally. Negative Fabere and negative pelvic compression test. Diagnostic Impression: Back and leg pain of a sprain/strain type pattern. Plan and Recommendation: The claimant reported that she had therapy which aggravated her pain, but did not give her any relief. I would recommend that the claimant be taught a program of physical activity, including stretching and low impact aerobics and be made to be responsible for her own therapy program. We will send her back to therapy with that as the goal. I would recommend that she walk for an hour and twenty to and an hour and thirty minutes daily and she can break that up into two sessions if she prefers. We will also give her some Lodine and Tramadol and stop any muscle relaxants and short term anti-inflammatories. There is no basis for her to have any specific restrictions of her work activities and she indicated that she is actually working.

03-06-12: History and Physical dictated by DO. Claimant has been referred to a spine surgeon for work hardening program. Claimant continues to have some back pain for which she is taking medications. Physical Exam: Structural exam: Exam today reveals continued paravertebral muscle spasm of the lumbar spine. Claimant does not exhibit any signs of Radiculopathy. Impression: 1. Low back pain, claimant in the work hardening program. Plan and Recommendation: The claimant has no contraindications to participating in the program.

03-06-12: Functional Capacity Evaluation dictated by DC. Job demand level is a category of Medium work. Assessments: 1. The claimant cannot safely perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes.

03-16-12: Discharge summary dictated by PT, DPT. Claimant presented with continued low back pain with bending and activity. She does not feel like she can return to full duty at work. Claimant feels like the cramps and pain in her legs has improved with the stretching exercises. Assessment: The claimant has made some improvement in LE symptoms with decreased cramping and radiating pain since exercising. She continues to be guarded and anxious about movement and transitions and reports low back pain limiting her activity. She has been given introductory core strengthening exercises but we were unable to progress exercises per claimant citing pain limitations. She has not been compliant with aerobic exercises like walking complaining of increased pain.

03-22-12: Office note dictated by MD. Problem: Low back pain. The claimant continues to have persistent back pain. The claimant has completed physical therapy, but her back pain has not resolved and is currently working light duty. The claimant is walking with a very slow gait. Range of motion of the lumbar spine is decreased secondary to pain. The MRI performed about 5 months prior showed small bulges at L3-L4 and L4-L5, two months after injury. I informed the claimant that sometimes changes in lumbar spine as a result of injury do not show up for six months. We would continue conservative treatment at this time. If she continues having persistent symptoms, we might be able to renew and update her MRI to figure out if there is a reason for her continuous pain. Continue with anti-inflammatories, continue with exercises. Claimant will remain on light duty and follow up in one month.

04-19-12: Office visit note dictated by MD. Problem: Lumbar disc protrusion and lumbar disc disruption. Claimant continues to have persistent back pain going down her left leg and is located on the anterior left leg, radiating down to her lateral side of the left foot. Claimant is still in physical therapy and work conditioning program without any improvement. Physical exam does not reveal any motor deficit in the lower extremities and her reflexes were intact. Claimant is probably suffering from discogenic pain since she assured me that her back pain is worse than the left leg pain. Ruptured disc does not show up on an MRI for about three to six months. We will update her MRI.

05-02-12: UR performed by MD. Reason for denial: I do not recommend approval for the requested repeat lumbar MRI, for this 42 yo female, s/p episode on 8/30/11 when lifting trash bags, with low back pain and bilateral leg pain, treated with PT, medications, and a work hardening program, etc, but without clear medication treatment as the present time, for the following reasons: 1. The patient is stated to have low back and bilateral leg pain, more to the left, 2. The symptoms are not clearly in a radicular pattern, but may be in L4-S1, 3. There has never been any clear and constant objective findings of Radiculopathy, i.e. LOS, change in sensation or reflexes, 4. Imaging (MRI), without mention of quality issues, on 10/6/11 does not show neurocompression, fracture or instability, and there has been no clear and well documented change in symptoms and signs, 5. This would not be consistent with ODG, 2012, Low Back, February, MRIs, etc. 6. There is no information from the provider to justify the repeat procedure.

05-17-12: Office visit note dictated by MD. Problem: Lumbar disc disruption. Claimant continues to have persistent back pain and now the pain extends into her hips. We will request an updated MRI to pinpoint the source of her pain.

05-31-12: UR performed by MD. Reason for denial: The ODG states that repeat MRIs are not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The claimant has back and lower extremity pain, back pain worse than leg pain. However, she has normal lower extremity strength and reflexes which have been

unchanged. Without objective findings to correlate with her pain complaints and without an indication that this represents a significant change, I cannot recommend a repeat lumbar MRI as being medically necessary.

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

I would uphold/agree with previous denials. ODG states “Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology.” The claimant’s symptoms from day one throughout present time have been neck pain, arm pain, back pain, bilateral leg pain. Neurological examination has been inconsistent and it does not follow any dermatological distribution. The claimant had no changes in her condition that would now indicate that she has developed a herniated disc as compared to the first MRI which did not show a herniated disc. After reviewing the medical records there is no documentation of any significant changes or clinical findings suggestive of significant pathology that would indicate a repeat MRI would be medically necessary. Therefore, the request for Repeat Lumbar MRI is denied.

**Per ODG: MRIs**

<p>(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). (<a href="#">Bigos, 1999</a>) (<a href="#">Mullin, 2000</a>) (<a href="#">ACR, 2000</a>) (<a href="#">AAN, 1994</a>) (<a href="#">Aetna, 2004</a>) (<a href="#">Airaksinen, 2006</a>) (<a href="#">Chou, 2007</a>) 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. (<a href="#">Seidenwurm, 2000</a>) 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. (<a href="#">Jarvik-JAMA, 2003</a>) 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. (<a href="#">Videman, 2003</a>) 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. (<a href="#">Carragee, 2004</a>) 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%. (<a href="#">Kinkade, 2007</a>) Baseline MRI findings do not predict future low back pain. (<a href="#">Borenstein, 2001</a>) 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. (<a href="#">Carragee, 2006</a>) MRI abnormalities do not predict poor outcomes after conservative care for chronic low back pain patients. (<a href="#">Kleinstück, 2006</a>) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging</p>
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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](#)) 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

	<ul style="list-style-type: none"> <li>- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)</li> <li>- Uncomplicated low back pain, suspicion of cancer, infection, other “red flags”</li> <li>- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.</li> <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)