AccuReview

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: March 1, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI Lumbar 72148

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

This physician is Board Certified in Anesthesiology and Pain Management 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:

06-22-06: MRI Lumbar Spine W/O Contrast interpreted by
06-23-06: Established patient Visit by
08-01-06: History and Physical by
08-17-06: Operative Report by
08-24-06: Operative Report by
08-31-06: Operative Report by
09-20-06: Progress Note by
09-25-06: Letter by

10-18-06: Progress Note by
11-20-06: Progress Note by
12-18-06: Progress Note by
01-15-07: Progress Note by
02-12-07: Progress Note by
04-09-07: Progress Note by
05-07-07: Progress Note by
06-04-07: Progress Note by
07-02-07: Progress Note by
10-01-07: Progress Note by
10-29-07: Progress Note by
01-21-08: Progress Note by
04-14-08: Progress Note by
07-10-08: Progress Note by
08-28-08: Progress Note by
11-10-08: Progress Note by
01-05-09: Progress Note by
03-02-09: Progress Note by
04-28-09: Progress Note by
04-28-09 through 07-08-09: Physical Modalities/Physical Therapy Progress Notes (8 sessions)
06-23-09: Progress Note by
09-10-09: Progress Note by
12-10-09: Progress Note by
03-04-10: Progress Note by
05-20-10: Progress Note by
08-19-10: Progress Note by
11-15-10: Progress Note by
02-15-11: Progress Note by
05-16-11: Progress Note by
08-15-11: Progress Note by
11-14-11: Progress Note by
12-12-11: Progress Note by
01-10-12: Progress Note by
01-19-12: UR performed by
02-03-12: UR performed by
02-07-12: Progress Note by

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured in xxxx on the job with initial complaints of pain in her lower back region that radiated down her right lower extremity. In 2003 she underwent back surgery. In 2006 her lumbar pain was re-occurring with radiation down in her left lower extremity.

06-22-06: MRI Lumbar Spine W/O Contrast interpreted by Impression: 1. L4-5 lateral canal recurrent disc herniation creating mass effect on the right anterior aspect of the thecal sac but no central spinal stenosis. There is mild right foraminal encroachment from disc bulge and facet hypertrophy. 2. Left sided L3-4 disc herniation in the far lateral canal and exit foramen, progressive from 2003 studies. 3. Right sided T11-12 disc herniation, progressive from 2003, not yet resulting in significant mass effect on the thecal sac and not flattening or displacing the conus.

06-23-06: Established patient Visit by Diagnosis: Lumbar radiculopathy and lumbar disc herniation. Plan: Referral for a course of lumbar epidural steroid injection. Prescribed Hydrocodone.

08-01-06: History and Physical by. On physical examination she had aches and pains in her lower back region and both lower extremities. She had subjective complaints of weakness, numbness, and tingling in her right lower extremity. Her reflexes were 2+ in her lower extremities bilaterally. She had negative straight leg raise test. Diagnosis: Lower back pain and lumbar radicular pain. Plan: Lumbar epidural steroid injections times 3. She was prescribed Lyrica 50 mg, and Elavil 10 mg. Physical modalities were also recommended.

08-17-06: Operative Report by. Postoperative diagnosis: Lumbar radicular pain. Procedures: 1. Fluoroscopic evaluation of the lumbar spine. 2. Diagnostic lumbar epidurogram. 3. Anesthetic injection per epidural catheter. 4. Steroid injection per epidural catheter. 5. Injection of hypertonic saline.

08-24-06: Operative Report by. Postoperative diagnosis: Lumbar radicular pain. Procedures: 1. Fluoroscopic evaluation of the lumbar spine. 2. Diagnostic lumbar epidurogram. 3. Anesthetic injection per epidural catheter. 4. Steroid injection per epidural catheter. 5. Injection of hypertonic saline.

08-31-06: Operative Report by. Postoperative diagnosis: 1. Lumbar radicular pain. 2. Lower back pain. Procedures: 1. Fluoroscopic evaluation of the lumbar spine. 2. Diagnostic lumbar epidurogram. 3. Anesthetic injection per epidural catheter. 4. Steroid injection per epidural catheter. 5. Injection of hypertonic saline.

09-20-06: Progress Note by. It was noted that the ESI injections helped the claimant quite a bit and the only discomfort that she had was cramping in her right foot. On physical exam her motor and sensory exam was intact. She was prescribed Quinine Sulfate 260 mg.

04-09-07: Progress Note by. It was noted that the claimant's current medical therapy was giving her about 80% relief. She was given prescriptions for Lyrica 50 mg, Elavil 10 mg, Vicodin ES and Relafen 500 mg.

01-05-09: Progress Note by. It was reported that the claimant was having significant pain in both sacroiliac joints. The claimant reported that Relafen and Vicodin had not

been as helpful with her pain. On examination of the sacroiliac area pain was elicited along both sacroiliac joints on palpation. She had positive Fabere's. L1 through S2 were intact. Bilateral sacroiliac joint injections were recommended. She was prescribed Vicodin ES, Elavil 25 mg, Lyrica 50 mg, and Motrin 80 mg.

03-02-09: Progress Note by. It was reported the claimant was having a little bit more severe pain in her lower back. recommended lumbar epidural steroid injections times 3.

04-28-09: Progress Note by. It was noted the injections had been denied. Physical therapy was recommended.

02-15-11: Progress Note by. It was reported that the claimant was doing well with her current prescriptions and that her back pain was well managed with her medications. On physical exam L1 through S2 was intact. The following prescriptions were refilled: Ibuprofen 800 mg, Lyrica 50 mg, Elavil 25 mg, Skelaxin 800 mg, and Vicodin 10 mg.

05-16-11: Progress Note by. No change documented.

08-15-11: Progress Note by. It was reported that as of lately the claimant had been experiencing more pain to the lumbosacral area and lateral aspect of her hips. She had difficulty sleeping at night due to the pain. On physical exam L1 through S2 was intact. Negative straight leg raise test. Pain was localized over both trochanteric bursa on palpation. Diagnosis: Low back pain and musculoskeletal pain. Medications were refilled, the claimant was advised the symptoms did not seem to be related to her lower back and to discuss with PCP an evaluation of these areas.

11-14-11: Progress Note by. On physical exam there was well preserved range of motion in the lumbar region. She was able to flex vertebrally to about 70 degrees with no radiating pain. Options were discussed including regular therapeutic exercise and consideration for treatments for fibromyalgia.

12-12-11: Progress Note by. It was recommended she continue conservative therapy. The following prescriptions were refilled: Elavil 25 mg, Skelaxin 800 mg, Vicodin HP 10 mg, Lyrica 75 mg, and Motrin 800 mg. Lumber ESIs times 3 were also recommended.

01-10-12: Progress Note by. It was reported the ESIs were denied. The claimant reported severe chronic pain in her lower back region and that her current medical therapy was only minimally given her relief. On physical exam motor and sensory was intact in the lower extremities. A MRI of the lumbar spine was recommended.

01-19-12: UR performed by. Rationale: As per medical report date 01-10-12, the patient complains of severe chronic pain in her lower back region. On physical examination, motor and sensory is intact in the lower extremities. This is a request for repeat MRI of the lumbar spine. The provider stated that the patient has worsening back pain. However, the recent physical examination findings revealed intact motor and sensory functions. A comprehensive physical examination was not documented.

Additionally, there is no documentation of progressively deteriorating neurological deficits. With these, the need for the request is not substantiated at this time.

02-03-12: UR performed by. Rationale: The current request was previously denied due to lack of objective documentation of progressively deteriorating neurological deficits. The provider stated that the patient has worsening back pain. However, the recent physical examination findings revealed intact motor and sensory functions. A comprehensive physical examination was still not documented. Additionally, there is still no documentation of progressively deteriorating neurological deficits. With these, the previous non-certification of the request is upheld.

02-07-12: Progress Note by. It was noted that she had no other new complaints, just quite a bit of discomfort in her lower back region. On physical examination, motor and sensory exams were intact in the lower extremities. Diagnosis remained lower back pain and lumbar radicular pain. Plan: To continue with conservative therapy. Prescriptions were refilled as follows: Elavil 25 mg, Skelaxin 800 mg, Vicodin 10 mg, Lyrica 75 mg, Motrin 800 mg, and Ultram 50 mg.

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

The previous determinations are upheld. The claimant had an intact sensory and motor examination on the last examination on 02/07/2012. The findings were an increase in discomfort in her lower back with no signs of progression of anatomic difficulties. The treating physician stated in his plan: "Patient is to continue with conservative therapy at this time." ODG guideline for repeat MRI states, "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)." There were no significant changes documented on physical exam.

Thus, this is a concurrence with the two previous UR reviewers: 01/10/2012, by, and 02/03/2012 by The request for a repeat Lumbar MRI is denied.

ODG:

MRIs (magnetic resonance imaging)

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 controversary 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) 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.
- 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)**