

# True Decisions Inc.

An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW:** 5-10-2008

**IRO CASE #:**

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

X-rays Lumbar spine 8-views

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

Chiropractor  
AADEP Certified  
Whole Person Certified  
TWCC ADL Doctor  
Certified Electrodiagnostic Practitioner  
Member of the American of Clinical Neurophysiology  
Clinical practice 10+ years in Chiropractic WC WH Therapy

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Adverse Determination Letters 3/14/08 and 4/10/08  
Letter Dr. dated 4-25-2008  
Re-eval Dr. 3-05-2008

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured employee was involved in an occupational injury. The injured employee injured his low back on XX/XX/XX. The injured employee eventually underwent a first surgery on April 2000 and a follow-up surgery on July 2003. The injured employee is now undergoing pre-authorization for 8-view radiographs of the lumbar spine to determine loose hardware and instability which may be causing increased symptoms.

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

The medical necessity for 8-views of the lumbar spine is not supported in documentation. ODG and the Texas Labor Code do not specifically address the issue of the numbers of x-rays as to the recommendation of x-rays. Other medical standards would concur that motion study x-rays (flexion & extension) are necessary to determine instability and motion. Medical records reviewed do not support 8-views of the lumbar spine.

**Guidelines.** 1) Lateral flexion and extension radiography is recommended as an adjunct to determine the presence of lumbar fusion postoperatively. The lack of motion between vertebrae, in the absence of rigid instrumentation, is highly suggestive of successful fusion.

Therefore, the request for 8-views of the lumbar spine would be considered not medically necessary.

**Pre-Operative Surgical Indications Recommended:** Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see [discography criteria](#)) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) [Psychosocial screen](#) with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. ([Colorado, 2001](#)) ([BlueCross BlueShield, 2002](#))

**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)