



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of computed Tomography, lumbar Spine; without contrast material.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of computed Tomography, lumbar Spine; without contrast material.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties:

MD and Liberty Mutual Group

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD:

MD and Memorial Hospital:

Operative Reports – 5/20/92, 4/13/04, 4/30/04, 5/11/05, 7/26/05, 5/1/07
5/23/07, 10/14/08, 2/4/09, 10/27/10, 11/3/09, 4/5/11, 12/20/11

History and Physical Reports – 4/13/04, 4/30/04, 3/15/05, 5/11/05,
1/28/09, 3/4/09, 11/3/09, 10/27/10, 12/20/11

Radiology Reports – 5/20/92, 4/13/04, 4/30/04, 5/20/04, 7/26/05, 3/8/07,
4/16/07, 5/23/07, 10/14/08, 1/28/09, 2/6/09, 4/21/09, 8/17/09,
9/17/09, 6/15/10, 8/17/10, 12/6/10, 12/7/10, 2/24/11, 10/3/11

Intraoperative Evoked Potentials Monitoring Report – 4/30/04, 10/27/10

Consultation Report – 5/1/04, 1/28/09, 3/4/09, 11/29/10

Discharge Summary – 5/2/04, 2/5/09, 3/6/09, 10/29/10

Post-Op Radiology report – 8/2/04, 10/18/04, 12/13/04, 2/24/05, 6/16/05,
5/18/06

Medical Center

Bilateral Lumbar Radiculopathy Report – 4/7/11

Immediate Result Report – 10/18/10
Neurosurgical Assoc
Office Note – 12/13/90, 4/16/92
MD
Office Note – 2/16/04, 3/29/04, 4/19/04, 5/20/04, 8/2/04, 10/18/04,
12/23/04, 2/24/05
Clinic Notes – 2/29/91-5/21/12
Records reviewed from liberty Mutual Group:
S Thao Letter – 6/8/12
LHL009 – 6/5/12
Liberty Mutual Denial Letters – 5/8/12, 5/15/12
Reconsideration Notice Letter – 5/11/12
Prium Pre-Auth Denial Letters – 5/8/12, 5/15/12
R LeGrand, Jr, MD Precert Request – 5/3/12
Appeal Request – 5/9/12
Shannon Medical Center Lumbar Myelogram – 5/23/07
CT Scan Lumbar Spine – 5/23/07
A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient continues with severe back pain. The Attending Physician's treatment records have included evidence of prior lumbar laminectomies and discectomies, L2-4 fusion, with spinal cord stimulator insertion. Diagnoses have also included anterolisthesis, instability and stenosis. On 10/3/11, there was radiographic evidence of good alignment and no evidence of nonunion. Aching back, hips and legs were noted by the Attending Physician in 3/12. However, records as of 4/26/12 (as per denial letter also) reflected only cervical and lumbar symptoms without detailed exam abnormalities documented. Denial and appeal letters were reviewed.

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

Without delineation of specific trauma, radiculopathy, myelopathy, pars defects or evidence of nonunion of prior fusion, applicable clinical ODG criteria for such an imaging request has not been met. Therefore, the requested service is not medically necessary at this time.

ODG Lumbar Spine - CT (computed tomography):

Not recommended except for indications below for CT. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. (Seidenwurm, 2000) 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 computed tomography (CT) 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) 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)

Indications for imaging -- Computed tomography:

- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, infectious disease patient
- Evaluate pars defect not identified on plain x-rays
- Evaluate successful fusion if plain x-rays do not confirm fusion (Laasonen, 1989)

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)