

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

Date notice sent to all parties:

November 16, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal Request for 1 CT Scan of the lumbar spine without contrast

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

Board Certified Orthopedic Surgeon

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:

1. Cover sheet and working documents
2. Complex comprehensive medical evaluation dated 01/25/10
3. Office visit notes dated 02/29/12-06/29/12
4. Peer review report dated 03/12/12
5. MRI lumbar spine dated 04/19/12
6. Consultation note dated 08/27/12
7. Utilization review determination dated 10/15/12
8. Peer review report dated 10/15/12
9. Utilization review determination dated 10/23/12
10. Peer review report dated 10/23/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured worker is a female who reportedly was injured on xx/xx/xx when she slipped out of a chair and landed on her buttock. Records indicate that the Injured worker is status post L4-S1 360 fusion performed 10/27/03. She continues to complain of low back pain. She has been treated by pain management specialists, and was seen in consultation on 08/27/12. MRI of the lumbar spine dated 04/19/12 was reviewed and noted to show previous anterior posterior lumbar fusion L4-5 and L5-S1. There was some edema and enhancement surrounding the pedicle screw heads at L4, and there was also edema within the L3 and L4 vertebral bodies with mild enhancement. Differential diagnosis includes loosening of the hardware; however, findings are suspicious for possible discitis and osteomyelitis of L3 and the superior aspect of L4 vertebral body. noted that the injured worker did not have any manifestations whatsoever, in his opinion, of osteomyelitis. On examination, the injured worker was able to get on toes and heels and walks just fine on her toes, difficult on her heels. She forward flexes, puts her hands beneath her knees and stops, stands direct without climbing up to thighs. She can bend to the right, to the left approximately 10 degrees. She arches her back. Seated straight leg raise is up to passive 90 degrees, no retention. Manual motor testing was unremarkable in both lower extremities. The injured worker goes from standing to a seated posture with some difficulty, but not as anticipated for someone with osteomyelitis. In the supine posture, leg raises are negative 90 degrees, no withdrawal whatsoever. There are no SI joint rotation sites.

A request for CT scan of the lumbar spine without contrast was non-certified per review dated 10/15/12 at which time it was noted that the medical report dated 08/28/12 did not contain a comprehensive examination of the injured worker's lumbar spine, with objective elaboration of range of motion, palpatory examination, manual motor testing, determination of sensory deficits and reflexes, along with orthopedic testing that not only provides an updated clinical status of the injured worker but also substantiates the necessity of the requested imaging study.

An appeal request for CT scan of the lumbar spine without contrast was non-certified by review dated 10/23/12. The reviewer noted that there was no documentation of objective findings on physical examination of progressive neurological deficits, and there was no documentation that the injured worker has undergone plain x-rays to confirm the suspected nonunion of the lumbar spine, nor is there any documentation that a bone scan has been performed to rule out osteomyelitis.

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

The request for CT scan of the lumbar spine without contrast is not supported as medically necessary based on the clinical data provided. The injured worker has a history of 2-level 360 fusion L4-S1 performed 10/27/03. She continued with low back pain. MRI on 04/19/12 revealed postoperative changes with anterior and posterior lumbar fusion at L4-5 to L5-S1. There were findings suggesting of

possible loosening of hardware, but findings were noted to be suspicious for possible discitis and osteomyelitis. The most recent examination did not include assessment of motor, sensory, and reflex functions. There was also no indication that the injured worker has had plain radiographs of the lumbar spine that failed to demonstrate solid fusion. Based on the clinical data provided, the request does not meet ODG criteria and medical necessity is not established.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

OFFICIAL DISABILITY GUIDELINES LOW BACK CHAPTER

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](#)) For suspected spine trauma (ie, fractures, lumbar or cervical), thin-section CT examination with multiplanar reconstructed images may be recommended. Image software postprocessing capabilities of CT, including multiplanar reconstructions and 3-dimensional display (3D), further enhance the value of CT imaging for reconstructive trauma surgeons. ([Daffner, 2009](#))

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](#))