

Notice of Independent Review Decision

**October 29, 2013**

**IRO CASE #:**

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

CT Thoracic w/o Contrast

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. The physician is certified in pain management. The physician has a private practice of Physical Medicine & Rehabilitation. The physician is a member of the Texas Medical Association and the Houston Physical Medicine and Rehabilitation Society. The physician is licensed in Texas and Michigan and has been in practice for over 25 years.

**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 medical necessity exists for each of the health care services in dispute.

*Upon independent Review the physician finds that the previous adverse determination should be Overturned.*

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

Records Received: 17 page fax 10/09/13 Department of Insurance IRO request, 40 pages of documents received via fax on 10/10/13 URA response to disputed services including administrative and medical. Dates of documents range from 2/15/13 to 10/09/13.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

# The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-4443

This is a man who had a lumbar fusion at L5-S1 in 2005. He had a spinal stimulator inserted on 02/15/13 for post-laminectomy pain. The majority of the notes describe the lumbar pain and not the thoracic pain. wrote on 09/11/13 of the severe chest pain. He also pointed out that there were contraindications to the use of an MRI as a diagnostic test for people with spinal implants.

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

The *ODG* was used for the description of a CT scan for the upper back. As noted, most of the review is for people with acute problems. This is in the indications summarized. The *ODG*, however, does recognize that not all issues are addressed. It states, “**Repeat CT is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g. tumor, infection, fracture, neurocompression, recurrent disc herniation where MRI is contraindicated).**” While this is not a repeat CT scan, there is a “significant change in symptoms...suggestive of significant pathology...,” an infection, or misplaced wire/lead would fall into this category.

Computed Tomography (CT)	<p>Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (<a href="#">Anderson, 2000</a>) (<a href="#">ACR, 2002</a>) See also <a href="#">ACR Appropriateness Criteria</a><sup>TM</sup>. MRI or CT imaging studies are valuable when potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. (<a href="#">Bigos, 1999</a>) (<a href="#">Colorado, 2001</a>) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (<a href="#">Daffner, 2000</a>) (<a href="#">Bono, 2007</a>) CT scan has better validity and utility in cervical trauma for high-risk or multi-injured patients. (<a href="#">Haldeman, 2008</a>) <b>Repeat CT 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 where MRI is contraindicated).</b> (<a href="#">Roberts, 2010</a>)</p> <p><b>Indications for imaging -- CT (computed tomography):</b></p> <ul style="list-style-type: none"><li>- Suspected cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet</li><li>- Suspected cervical spine trauma, unconscious</li><li>- Suspected cervical spine trauma, impaired sensorium (including alcohol and/or drugs)</li></ul>
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	<ul style="list-style-type: none"><li>- Known cervical spine trauma: severe pain, normal plain films, no neurological deficit</li><li>- Known cervical spine trauma: equivocal or positive plain films, no neurological deficit</li><li>- Known cervical spine trauma: equivocal or positive plain films with neurological deficit</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)**