

CT Thoracic Spine

CPT: 72128, 72129, 72130

IMPORTANT NOTES

- If MRI is Preferred CT cannot be authorized without a statement that MRI is not available, has been done but was not diagnostic, or that the patient cannot tolerate an MR examination

Red Flags Disregard any requirement for prior management if any of the following are part of the clinical history:

- Abnormal CBC, Sed Rate, etc
- Bladder and Bowel dysfunction
- Fever
- Cancer, History of
- Immunocompromised state
- IV drug use
- Major weakness of a limb
- Pain increased at rest
- Saddle anesthesia
- Trauma
- Unexplained weight loss
- Urinary tract infections

The requirement for Medical or Conservative Management prior to imaging is satisfied if the following are met:

1. Nonsteroidal anti-inflammatory drugs for at least four weeks (Requirement is waived if NSAIDs are not tolerated or contraindicated, or if condition worsens while under treatment.)
2. Activity modification or physical therapy if appropriate

1 Major Symptom or Complaint presented as primary indication

1.1 Bladder dysfunction MRI is preferred unless contraindicated

1.2 Bowel incontinence MRI is preferred unless contraindicated

1.3 Burning sensations (dysesthesias)

1.3.1 Radiculopathy or disc disease suspected. Failed conservative management

1.4 Clumsiness, increasing with time

1.4.1 Myelopathy suspected

1.5 Gait disturbances

1.5.1 Myelopathy suspected

1.6 Loss of bowel or bladder control MRI is preferred unless contraindicated

1.7 Numbness, in nerve root distribution

1.7.1 Radiculopathy or disc disease suspected.

1.7.1.1 Failed conservative management

1.8 Pain, in back

1.8.1 Failed conservative management

1.8.2 Known malignancy elsewhere RED FLAG

1.9 Pain, local to spine or radiating in root pattern

1.9.1 No RED FLAGS, Failed conservative management

1.9.2 Suspected epidural abscess (Conservative Management not required)

1.9.2.1 AIDS

1.9.2.2 ESR elevated

1.9.2.3 Fever

1.9.2.4 Immunosuppressed

1.9.2.5 White count elevated

1.10 Sensory abnormality confirmed by examination

1.10.1 Myelopathy suspected

1.10.2 Radiculopathy or disc disease suspected. Failed conservative management

1.11 Severe pain, not responding to opiates or worsening, RED FLAG

1.12 Shooting pain, in nerve root distribution

1.12.1 Radiculopathy or disc disease suspected. Failed conservative management

1.13 Tingling sensations (paresthesias),

1.13.1 Radiculopathy or disc disease suspected. Failed conservative management

1.14 Weakness, in nerve root distribution

1.14.1 Radiculopathy or disc disease suspected. Failed conservative management

2 Working Diagnosis or Rule Out presented as primary indication

2.1 Bilateral radiculopathy

2.1.1 Myelopathy suspected

2.1.1.1 Failed Conservative Management AND ONE

2.1.1.1.1 Atrophy of upper extremity musculature

2.1.1.1.2 Burning sensations (dysesthesias)

2.1.1.1.3 Hyporeflexia

2.1.1.1.4 Numbness, in nerve root distribution

2.1.1.1.5 Shooting pain, in nerve root distribution

2.1.1.1.6 Tingling sensations (paresthesias),

2.1.1.1.7 Weakness, in nerve root distribution

- 2.2 Brachial Plexus Pathology (Plexopathy) MRI C Spine strongly preferred, may be approved if MRI C spine is not feasible or is nondiagnostic

2.2.1 Indications BOTH

2.2.1.1 History

2.2.1.1.1 Breast or lung cancer

- Aliya Qayyum, A. David MacVicar, Anwar R. Padhani, Patrick Revell, and Janet E. S. Husband Symptomatic Brachial Plexopathy following Treatment for Breast Cancer: Utility of MR Imaging with Surface-Coil Techniques Radiology March 2000 214:837-842

2.2.1.1.2 History of radiation therapy to the chest, breast or axilla

- Bowen, BC, Verma, A, Brandon, AH, Fiedler, JA Radiation-induced brachial plexopathy: MR and clinical findings AJNR Am J Neuroradiol 1996 17: 1932-1936

2.2.1.1.3 Palpable mass in neck or shoulder area

2.2.1.2 Symptoms of upper extremity

2.2.1.2.1 Numbness

2.2.1.2.2 Paresthesias

2.2.1.2.3 Radiating pain

2.2.1.2.4 Weakness

- 2.2.1.3 Note Plexopathy refers to an abnormality of the complex of nerve roots exiting the spine and organizing into the nerves serving the arm, trunk or legs. Symptoms may include burning, tingling, or numbness in a circumferential or dermatomal distribution. The symptoms may radiate to the hand or remain localized in the neck.

References

1. ACR Appropriateness Criteria Plexopathy p10 Accessed 12/28/08
2. Aliya Qayyum, A. David MacVicar, Anwar R. Padhani, Patrick Revell, and Janet E. S. Husband Symptomatic Brachial Plexopathy following Treatment for Breast Cancer: Utility of MR Imaging with Surface-Coil Techniques Radiology 2000 214: 837-842.
3. BC Bowen, A Verma, AH Brandon, and JA Fiedler Radiation-induced brachial plexopathy: MR and clinical findings AJNR Am. J. Neuroradiol., Nov 1996; 17: 1932 – 1936. Neurosurgical Focus Posted 04/02/2007 Accessed 1/4/09 @ http://www.medscape.com/viewarticle/553963_1
4. Bowen B, Seidenwurm DJ, Davis P, et al, Expert Panel on Neurologic Imaging, American College of Radiology, Appropriateness Criteria, Plexopathy, accessed at http://www.acr.org/SecondaryMainMenuCategories/quality_safety/app_criteria/pdf/ExpertPanelonNeurologicImaging/PlexopathyDoc12.asp 12/28/08
5. Devin K. Binder, M.D., Ph.D.; Justin S. Smith, M.D., Ph.D.; Nicholas M. Barbaro, M.D Primary Brachial Plexus Tumors: Imaging, Surgical, and Pathological Findings in 25 Patients Neurosurgical Focus Medscape Radiology accessed 12/28/08
6. Edward Fathers, David Thrush, Susan M Huson, and Andrew Norman Radiation-induced brachial plexopathy in women treated for carcinoma of the breast Clinical Rehabilitation, Feb 2002; 16: 160 – 165.
7. Neoplastic Brachial Plexopathy Author: Mark A Wren, MD, MPH, Medical Director, Department of Physical Medicine and Rehabilitation, HealthSouth Rehabilitation Hospital of Texarkana eMedicine Specialties > Physical Medicine and Rehabilitation > Plexopathy Updated: Jan 19, 2010 Accesed 3/15/10
8. Vincent J. Miele, M.D.; John A. Norwig, A.T.C.; Julian E. Bailes, M.D. Sideline and Ringside Evaluation for Brain and Spinal Injuries

2.3 Epidural abscess, Suspected MRI with gadolinium is preferred unless contraindicated

2.3.1 Suspected BOTH

2.3.1.1 Symptoms ANY ONE

2.3.1.1.1 Loss of bowel or bladder control

2.3.1.1.2 Muscle weakness

2.3.1.1.3 Pain, local to spine or radiating in root pattern

2.3.1.1.4 Paralysis

2.3.1.1.5 Sensory abnormality confirmed by examination

2.3.1.1.6 Tenderness over spine

2.3.1.2 Clinical Findings ANY ONE

2.3.1.2.1 AIDS

2.3.1.2.2 ESR Elevated

2.3.1.2.3 Fever

2.3.1.2.4 Immunosuppressed

2.3.1.2.5 Infection elsewhere

2.3.1.2.6 Positive blood culture

2.3.1.2.7 Recent spinal surgery or procedure

2.3.1.2.8 WBC elevated

References:

1. AS Baker, RG Ojemann, MN Swartz, and EP Richardson Spinal epidural abscess; N. Engl. J. Med., Sep 1975; 293: 463 – 468.
2. Davis DP; Wold RM; Patel RJ; Tran AJ; Tokhi RN; Chan TC; Vilke GM The clinical presentation and impact of diagnostic delays on emergency department patients with spinal epidural abscess. J Emerg Med 2004 Apr;26(3):285-91.
3. Darouiche RO; Hamill RJ; Greenberg SB; Weathers SW; Musher DM; Bacterial spinal epidural abscess. Review of 43 cases and literature survey. Medicine (Baltimore) 1992 Nov;71(6):369-85 [abstract]
4. David T Durack, MD, DPhil Daniel J Sexton, MD Epidural abscess UpToDate 15.2 accessed 07/09/07

2.4 Myelopathy Suspected MRI PREFERRED Lumbar myelopathy is evaluated by performing a Thoracic spine exam because the spinal cord ends at the approximate level of T12 or L1.

2.4.1 Bilateral radiculopathy

2.4.1.1 Failed Conservative Management AND ONE

2.4.1.1.1 Atrophy of upper extremity musculature

2.4.1.1.2 Burning sensations (dysesthesias)

2.4.1.1.3 Hyporeflexia

2.4.1.1.4 Numbness, in nerve root distribution

2.4.1.1.5 Shooting pain, in nerve root distribution

2.4.1.1.6 Tingling sensations (paresthesias),

2.4.1.1.7 Weakness, in nerve root distribution

2.4.2 Bladder dysfunction

2.4.3 Bowel incontinence

2.4.4 Clumsiness, increasing with time

2.4.5 Gait disturbances

2.4.6 Sensory abnormality objectively observed

2.4.7 Weakness in upper or lower extremities

2.4.7.1 Failed conservative management

References:

1. Rao, Raj D., Gourab, Krishnaj, David, Kenny S. Operative Treatment of Cervical Spondylotic Myelopathy J Bone Joint Surg Am 2006 88: 1619-1640
2. Rao R. Neck pain, cervical radiculopathy, and cervical myelopathy: pathophysiology, natural history, and clinical evaluation. J Bone Joint Surg Am.2002; 84:1872 -81

2.5 Osteomyelitis suspected MRI Preferred

2.5.1 Pain or Fever AND One

2.5.1.1 C reactive Protein elevated

2.5.1.2 Elevated ESR

2.5.1.3 Fever

2.5.1.4 Leukocytosis

2.5.1.5 Positive Blood Cultures

References:

1. Parsonnet Jeffrey, "Chapter 120. Osteomyelitis" (Chapter). Fauci AS, Braunwald E, Kasper DL, Hauser SL, Longo DL, Jameson JL, Loscalzo J: Harrison's Principles of Internal Medicine, 17th Edition: <http://www.accessmedicine.com/content.aspx?aID=2893649>.
2. Alok Kapoor, Stephanie Page, Michael LaValley, Daniel R. Gale, and David T. Felson Magnetic Resonance Imaging for Diagnosing Foot Osteomyelitis: A Meta-analysis Arch Intern Med, Jan 2007; 167: 125 – 132.
3. J. Herman Kan, Melissa A. Hilmes, Jeffrey E. Martus, Chang Yu, and Marta Hernanz-Schulman Value of MRI After Recent Diagnostic or Surgical Intervention in Children with Suspected Osteomyelitis Am. J. Roentgenol., Nov 2008; 191: 1595 – 1600.
4. Kuo-Chen Lee, Yi-Ting Tsai, Chih-Yuan Lin, and Chien-Sung Tsai Vertebral osteomyelitis combined streptococcal viridans endocarditis Eur. J. Cardiothorac. Surg., Jan 2003; 23: 125.
5. D Allen, S Ng, K Beaton, and D Taussig Sternal osteomyelitis caused by Aspergillus fumigatus in a patient with previously treated Hodgkin's disease J. Clin. Pathol., Aug 2002; 55: 616 – 618.
6. M Ida, H Watanabe, A Tetsumura, and T Kurabayashi CT findings as a significant predictive factor for the curability of mandibular osteomyelitis: multivariate analysis Dentomaxillofac. Radiol., Mar 2005; 34: 86 – 90.
7. Jyri K. Koort, Tatu J. Mäkinen, Juhani Knuuti, Jari Jalava, and Hannu T. Aro Comparative 18F-FDG PET of Experimental Staphylococcus aureus Osteomyelitis and Normal Bone Healing J. Nucl. Med., Aug 2004; 45: 1406 – 1411.
8. Susan A. Connolly, Leonard P. Connolly, Laura A. Drubach, David Zurakowski, and Diego Jaramillo MRI for Detection of Abscess in Acute Osteomyelitis of the Pelvis in Children Am. J. Roentgenol., Oct 2007; 189: 867 – 872.

2.6 Radiculopathy or Spinal Stenosis

2.6.1 Failed Conservative Management AND ONE

2.6.1.1 Atrophy of upper extremity musculature

2.6.1.2 Burning sensations (dysesthesias)

2.6.1.3 Hyporeflexia

2.6.1.4 Numbness, in nerve root distribution

2.6.1.5 Shooting pain, in nerve root distribution

2.6.1.6 Tingling sensations (paresthesias),

2.6.1.7 Weakness, in nerve root distribution

References:

1. Schwartz's Principles of Surgery, 8th Edition F. Charles Brunicaardi, et al opyright © 2005, The McGraw-Hill Companies, Inc. Chapter 41. Neurosurgery Michael L. Smith, M. Sean Grady
2. Douglas-Akinwande, Annette C., Rydberg, Jonas, Shah, Mitesh V., Phillips, Michael D., Caldemeyer, Karen S., Lurito, Joseph T., Ying, Jun, Mathews, Vincent P. Accuracy of Contrast-Enhanced MDCT and MRI for Identifying the Severity and Cause of Neural Foraminal Stenosis in Cervical Radiculopathy: A Prospective Study Am. J. Roentgenol. 2010 194: 55-61
3. Michael T. Modic, Nancy A. Obuchowski, Jeffrey S. Ross, Michael N. Brant-Zawadzki, Paul N. Grooff, Daniel J. Mazanec, and Edward C. Benzel Acute Low Back Pain and Radiculopathy: MR Imaging Findings and Their Prognostic Role and Effect on Outcome Radiology November 2005 237:597-604

2.7 Spinal Stenosis SEE Radiculopathy

2.8 Suspected Fracture

3 Abnormal Physical Exam Finding presented as primary indication

3.1 Hyporeflexia

3.1.1 Radiculopathy or disc disease suspected. Failed conservative management

3.2 Sensory abnormality confirmed by examination

3.2.1 Myelopathy suspected

3.2.2 Radiculopathy or disc disease suspected. Failed conservative management

3.3 Weakness, in nerve root distribution

3.3.1 Radiculopathy or disc disease suspected. Failed conservative management

4 Abnormal Lab or Imaging presented as primary indication

4.1 Fracture seen or suspected on recent x-ray

5 Significant Prior Medical History presented as primary indication

5.1 Epidural abscess, Known MRI with gadolinium is preferred unless contraindicated

5.1.1 Known After treatment

5.1.1.1 Interval Follow up

5.1.1.2 Recurrent or worsening symptoms

References:

1. AS Baker, RG Ojemann, MN Swartz, and EP Richardson Spinal epidural abscess; N. Engl. J. Med., Sep 1975; 293: 463 – 468.
2. Davis DP; Wold RM; Patel RJ; Tran AJ; Tokhi RN; Chan TC; Vilke GM The clinical presentation and impact of diagnostic delays on emergency department patients with spinal epidural abscess. J Emerg Med 2004 Apr;26(3):285-91.
3. Darouiche RO; Hamill RJ; Greenberg SB; Weathers SW; Musher DM; Bacterial spinal epidural abscess. Review of 43 cases and literature survey. Medicine (Baltimore) 1992 Nov;71(6):369-85 [abstract]
4. David T Durack, MD, DPhil Daniel J Sexton, MD Epidural abscess UpToDate 15.2 accessed 07/09/07

5.2 Infection or abscess, after treatment

5.3 Management and assessment of spinal injury.

5.4 Multiple Sclerosis MRI is preferred unless contraindicated

5.4.1 With symptoms attributable to a specific level. Not indicated for asymptomatic patients

References:

1. Adams and Victor's Neurology > Part 4. Major Categories of Neurologic Disease > Chapter 36. Multiple Sclerosis and Allied Demyelinative Diseases > Multiple Sclerosis > Pathologic Findings >
2. Multiple sclerosis. T2-weighted MRIs demonstrating multiple plaques in the periventricular white matter (left), emanating radially from the corpus callosum ("Dawson fingers") (middle), and cervical spinal cord (right). The radial orientation and periventricular location of cerebral lesions is typical of the disease.

5.5 Osteomyelitis Known MRI PREFERRED

5.5.1 Interval follow up during and after treatment

5.5.2 Preoperative

5.5.3 Worsening clinical situation

References:

1. Parsonnet Jeffrey, "Chapter 120. Osteomyelitis" (Chapter). Fauci AS, Braunwald E, Kasper DL, Hauser SL, Longo DL, Jameson JL, Loscalzo J: Harrison's Principles of Internal Medicine, 17th Edition: <http://www.accessmedicine.com/content.aspx?aID=2893649>.
2. Alok Kapoor, Stephanie Page, Michael LaValley, Daniel R. Gale, and David T. Felson Magnetic Resonance Imaging for Diagnosing Foot Osteomyelitis: A Meta-analysis Arch Intern Med, Jan 2007; 167: 125 – 132.
3. J. Herman Kan, Melissa A. Hilmes, Jeffrey E. Martus, Chang Yu, and Marta Hernanz-Schulman Value of MRI After Recent Diagnostic or Surgical Intervention in Children with Suspected Osteomyelitis Am. J. Roentgenol., Nov 2008; 191: 1595 – 1600.
4. Kuo-Chen Lee, Yi-Ting Tsai, Chih-Yuan Lin, and Chien-Sung Tsai Vertebral osteomyelitis combined streptococcal viridans endocarditis Eur. J. Cardiothorac. Surg., Jan 2003; 23: 125.
5. D Allen, S Ng, K Beaton, and D Taussig Sternal osteomyelitis caused by Aspergillus fumigatus in a patient with previously treated Hodgkin's disease J. Clin. Pathol., Aug 2002; 55: 616 – 618.
6. M Ida, H Watanabe, A Tetsumura, and T Kurabayashi CT findings as a significant predictive factor for the curability of mandibular osteomyelitis: multivariate analysis Dentomaxillofac. Radiol., Mar 2005; 34: 86 – 90.
7. Jyri K. Koort, Tatu J. Mäkinen, Juhani Knuuti, Jari Jalava, and Hannu T. Aro Comparative 18F-FDG PET of Experimental Staphylococcus aureus Osteomyelitis and Normal Bone Healing J. Nucl. Med., Aug 2004; 45: 1406 – 1411.
8. Susan A. Connolly, Leonard P. Connolly, Laura A. Drubach, David Zurakowski, and Diego Jaramillo MRI for Detection of Abscess in Acute Osteomyelitis of the Pelvis in Children Am. J. Roentgenol., Oct 2007; 189: 867 – 872.

5.6 Prior to Surgical Intervention, as a road map for the surgeon

5.7 Trauma

5.7.1 Abnormal or nondiagnostic prior x-ray

5.7.2 Midline spinal tenderness

5.7.3 New onset of neurologic findings