



## IMED, INC.

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081  
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584  
e-mail: imeddallas@msn.com

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 04/22/09

**IRO CASE NO.:**

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

Item in dispute: Outpatient CT scan of the lumbar spine

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

**REVIEW OUTCOME**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Total bone scan, 03/23/00
2. D.C., 02/20/01 to 02/11/09
3. Designated Doctor Evaluation, 12/18/01
4. Required Medical Evaluation by Dr., 04/06/06
5. Lumbar myelogram, 07/20/06
6. Chiropractic office notes from February, 2007 thru December, 2007
7. Left knee MRI, 09/04/07
8. Peer review by M.D., 11/06/07
9. Lumbar spine x-ray, 01/14/09
10. M.D., orthopedic evaluation of the knee, 01/15/09
11. Chiropractic notes, 01/19/09 thru 02/11/09
12. Knee surgery report, 02/19/09
13. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The records appear to suggest that the employee was approximately when he was injured on xx-xx-xx. It was reported that the employee was at work as a when he was involved in some sort of altercation. The employee was running to the altercation area and slipped on a freshly waxed floor. The report suggests that the employee landed on his knees and then fell backwards onto his back.

The employee had a lumbar spine MRI in May, 1999 which revealed diffuse spondylitic change with mild to moderate spinal stenosis and disc bulges with osteophytes between L2 through L4 along with right lateral recess stenosis due to disc herniation at L4-L5. A thoracic spine MRI was also performed in March, 1999 revealing mild disc bulges at several levels without spinal cord impingement or stenosis.

It appears that the employee began treating with a local chiropractor, Dr., in May, 1999 and Dr. an orthopedic surgeon, also began treating the employee in May, 1999 with a diagnosis of spinal stenosis.

The employee did receive an EMG study which suggested bilateral L5 radiculopathy, and a CT scan of the lumbar spine was performed in January, 2000 revealing diffuse degenerative disc disease with spondylosis and a central canal stenosis of 8 mm at L2-L3.

Repeat MRIs of January, 2000 revealed the same condition, and a total body scan of March, 2000 revealed osteoarthritis in the dorsal spine only.

It appears the employee underwent a surgical opinion with Dr. in June, 2000, and a discogram was performed in August, 2000.

Eventually, the employee was recommended to undergo surgery and had a repeat opinion by Dr. on 01/26/01.

The employee was eventually placed at Maximum Medical Improvement (MMI) due to statutory law on 12/18/01. An impairment rating of 17% was awarded.

The employee later underwent lumbar surgery by Dr. consisting of a four level laminotomy and bilateral foraminotomy between L2 through S1 with fusion between L3 to S1.

The employee also had a repeat operation performed by Dr. on 06/15/04. The employee underwent laminotomies and bilateral foraminotomies at L3-L4, L4-L5, and L5-S1. Posterior segmental instrumentation was also removed.

It was noted that by February, 2006, the employee had a diagnosis of diabetes mellitus, and a repeat CT scan of the lumbar spine with myelography was recommended.

Apparently, a neurosurgeon was asked to evaluate the employee for a Required Medical Evaluation (RME) on 04/05/06. Dr. performed this evaluation and noted an overweight male with a height of 5 foot 8 inches and a weight of 255 pounds. The employee had high blood pressure of 164/98 and had normal motor strength in the upper and lower extremities without atrophy or fasciculation. Reflexes were considered to be depressed at 1/4 but symmetric. The sensory examination was unremarkable to pinprick in both arms and both legs symmetrically. However, the employee did have an antalgic gait.

The questions asked of the RME physician included a determination for the need of chiropractic care, along with any current diagnoses. It was felt that the employee had a diagnosis of chronic failed back syndrome and that he would require medications for the management of his current back pain. Chiropractic care was no longer felt to be reasonable.

It appears that throughout the remainder of the year of 2006, the employee was seen by an additional amount of physicians. Radiographs were performed in July, 2006.

By June, 2007, the employee underwent a mental health evaluation, and by November, 2007, another review of the employee's case was performed. Dr. performed a peer review on 11/06/07. Dr. felt that the employee had no need for ongoing treatment for knee complaints, but he felt that for the failed back syndrome, analgesic medications in the form of Vicodin would be appropriate.

It appears that in July, 2006, the employee had a CT scan of the lumbar spine following myelography. The results of this study confirmed on evidence of focal disc herniation at T12-L1. However, there was circumferential bulging at L1-L2, and there was mild posterior degenerative spurring along with some ligamentum flavum hypertrophy and facet hypertrophy.

At L2-L3, there was also circumferential disc bulging with moderate degenerative facet disease bilaterally.

At L3-L4, the employee was documented as having a prior wide bilateral laminectomy with no evidence of focal disc herniation. There was apparently an old pedicle screw track present. Evidence of prior posterolateral bony fusion was also documented.

At L4-L5, there was evidence of a prior bilateral laminectomy along with a posterolateral bony fusion. No spinal canal stenosis was present.

At the level of L5-S1, there was evidence of a wide bilateral laminectomy that had been performed along with a posterolateral body fusion. Again, there was no central canal stenosis.

Notes provided by Dr. in 2007 ranging from February, 2007 through December, 2007 were next reviewed. It was reported that the employee was having back pain as of 02/06/07. He apparently continued to have difficulties with his back. The pain was also consistent and considered to be constant. The employee was still using the cane for assistance for ambulation.

An evaluation of the employee noted that he could stand on his toes and heels with mild difficulty and that there was marked muscle spasm in the lumbar spine. Decreases in the lumbar range of motion were also documented.

Apparently in January, 2008, Dr. wrote in his narrative that the employee was complaining of erectile dysfunction. It was mentioned that the employee was having intercourse with his wife every three months. There were no other focal neurologic

deficits or signs of central canal stenosis documented during that evaluation, only the subjective complaint of erectile dysfunction which was causing Dr. to suggest the need for a urology consultation.

By January, 2009, Dr. wrote in his note that the employee had decreased sensation of vibration and light touch to the medial right leg greater than the left leg. However, a review of the notes also suggested that back in May, 2007 the employee was also having this same type of decreased vibratory sensation all the way down to his toes, and this would suggest that there has been no significant change in approximately two years between May, 2007 and the present notes of January, 2009.

Radiographs were apparently taken on 01/14/09, and it noted degenerative joint disease with a posterior laminectomy from L3 to L5. It was mentioned in the radiograph report that there was a bone graft present at L5-S1, but it was mentioned that it was difficult to determine if the posterior lateral fusion was solid and incorporated into the L3 level. A lumbar radiograph series was documented as a five view series. No flexion and/or extension studies were documented.

The next pertinent records were documented on 02/24/09 and 03/18/09. At that point, two preauthorization requests were reviewed for a CT scan of the lumbar spine. Dr. had apparently been recommending a CT scan due to the documentation by the radiologist as noted in the lumbar spine radiograph on 01/14/09. Dr. was quoting the radiograph report which stated "CT with reconstructions is clinically appropriate to evaluate the posterolateral fusion mass". Dr. suggested that this radiologist felt it was clinically necessary for a CT scan even though the report actually stated that a CT scan was only necessary if it was clinically correlated.

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

Both of the preauthorization requests on 02/24/09 and 03/18/09 are denied for the request for the CT scan.

The employee did sustain some form of injury on 03/13/99 which resulted in at least two surgical procedures for some preexisting degenerative changes.

The employee has been followed by a chiropractic neurologist, Dr. and at least between May, 2007 through January, 2009, the employee has had no significant changes in his subjective complaints or objective findings. Dr. did make mention that the employee had an intermittent erectile dysfunction problem, but he felt to document any other historical signs or objective focal neurological deficits which would suggest any significant objective change in the employee's condition.

There was also mention made by Dr. that the employee was having change in vibratory sensation in January, 2009, but this was also mentioned in May, 2007. This would suggest a two year stability at a minimum.

It appears that Dr. has now recommended a CT scan based on a vague mention by a radiologist that a CT scan would be necessary if clinically correlated. Dr. appeared to

misinterpret this statement stating in one letter that the radiologist found clinical evidence to support the need of a CT scan. This was an erroneous statement made by Dr. and in fact the radiologist merely stated that if there was any clinical evidence to support a CT scan, then it would be warranted.

Nevertheless, this case has been reviewed by multiple physicians on at least two other occasions, and they determine that a CT scan was not reasonable or medically necessary. This was the denial of two utilization review reports that confirmed that a CT scan was not reasonable or medically necessary.

The **Official Disability Guidelines** were utilized during the preauthorization reviews to determine the medical necessity of the CT scan, and the **Official Disability Guidelines** were also used during this independent review organization decision. The **Official Disability Guidelines** for CT scan regarding the lumbar spine suggests that there should be lumbar spine trauma and/or neurologic deficit. There should be lumbar spine trauma with seatbelt fracture. There should be myelopathy including neurologic deficit related to the spinal cord and/or there should be myelopathy with infectious disease. This employee does not meet any of those criteria. As previously mentioned, the employee has been stable since at least May, 2007 by Dr. own notes. Additionally, there has been no documented trauma or any documented objective changes which would warrant a CT scan at this time.

In summary, the request for a lumbar spine CT scan is not reasonable or medically necessary. The **Official Disability Guidelines** do not support the use of CT scans without objective evidence to clinically correlate the need for this CT scan with the employee's condition.

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

##### **1. *Official Disability Guidelines***