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Notice of Independent Review Decision

DATE OF REVIEW: August 19, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar CT scan to include CPT code #72131

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

American Board of Neurological 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY:

The patient is a xx-year-old male with an alleged work-related incident which occurred on xx/xx/xx.

The patient underwent a lumbar laminectomy and fusion on September 9, 2003.

The records resume with physician visits on February 27, 2006.

The patient saw , M.D., with complaints of intermittent left lower extremity tingling. He had full strength on examination and 1+ reflexes.

The patient saw Dr. again on April 24, 2006, with complaints of low back pain and left lower extremity pain. Dr. indicated that the patient had a chronic pain syndrome.

On April 16, 2008, Dr. indicated that the patient had developed increasing low back pain two days prior. The patient also complained of bilateral anterior thigh pain. On examination, he had full strength and absent ankle jerks.

Lumbar spine x-rays obtained on April 30, 2008 documented a solid fusion at L4-5 with slight listhesis at L1-2, L2-3, and L3-4.

On May 5, 2008, Dr. noted complaints of increasing low back pain and radiation into both lower extremities, left greater than right. On examination, Dr. noted full strength except for 5-/5 strength in the right soleus and 4+/5 strength in the left soleus. The patient's ankle jerks were absent.

A CT scan was obtained on May 14, 2008. This revealed a solid fusion at L4-5. There was a mild bulge at L3-4. There was a 1-2 mm retrolisthesis of L5 on S1. There was no stenosis and no mention of nerve root compression.

There is an approximately nine-month gap in treatment. The patient was then seen again by Dr. in February of 2009, with similar complaints of low back pain and left hip pain.

In May of 2009, repeat lumbar spine x-rays revealed a solid fusion.

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

The request is for a lumbar CT scan. This study is not indicated because there have been no objective changes in the patient's examination since his last CT scan. On May 5, 2008, Dr. noted complaints of increasing low back pain and bilateral lower extremity pain, left greater than right. On examination, the patient had 5-/5 strength in the right soleus and 4+/5 strength in the left soleus, with absent ankle jerks. Subsequently, a CT scan was performed of the lumbar spine on May 14, 2008. This revealed a solid fusion and no evidence of nerve root compression. According to the most current notes from Dr. in May of 2009, there has been no change in the patient's examination and, therefore, no new objective findings since the scan of May 14, 2008. Therefore, there is no indication for a new CT scan.

In addition, based on ODG of page 621, the indications for CT scanning are the following: thoracic spine trauma, lumbar spine trauma, and neurological deficit, myelopathy, with a neurological deficit, and a myelopathy due to infectious disease, pars defect. The patient has none of these findings, and therefore, the CT scan is not indicated.

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)**