

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 23, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT scan of the lumbar spine, 72131

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

MD, Board Certified Orthopedic Surgeon

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 or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for CT scan of the lumbar spine, 72131.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/20/08, 11/17/08
ODG Guidelines and Treatment Guidelines
Notes, Dr. : 04/30/08, 06/18/08, 07/02/08, 07/07/08, 07/08/08, 07/11/08, 07/30/08, 09/15/08, 11/14/08, 11/17/08 and 11/19/08
Office Visit, Dr. : 05/05/08, 07/01/08 and 10/09/08
Patient Health History Update: 05/19/08, 06/09/08, 06/18/08, 06/30/08, 07/07/08, 07/23/08, 08/20/08, 09/15/08 and 10/08/08
Medication Record: 05/19/08 through 11/10/08
Office Note, Dr. : 06/27/08

Radiology Report: 07/07/08, 07/25/08 and 09/18/08
Laboratory Report: 07/07/08
Office Visit, Dr. : 07/08/08
History and Physical, Dr. 07/08/08
Operative Report: 07/10/08
Prescription: 09/15/08
Radiology Exam Request: 10/14/08
Letter: 10/20/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old male worker with a reported low back injury on xx/xx/xx when he turned while working and felt a pop in his back. One month later he reported right lateral leg pain. Initial treatment records were not provided for review. Reference was made to an MRI on 07/28/06 and radiographs on 04/03/07 without a report or findings noted. Reference was also made to a CT/ discogram from 10/26/06 that was noted to be positive at L4-5 and L5-S1 and negative at L3-4. The report was not provided. Lumbar radiographs completed on 04/30/08 with oblique views noted well maintained height, adequate density and looked stable. Dr. saw the claimant on 05/05/08 with notation the claimant had no prior low back conditions, was a nonsmoker and had treated conservatively with two injections, physical therapy and medications including Hydrocodone. The claimant was noted to be off work. Physical examination demonstrated limited lumbar motion, positive right straight leg raise, positive bilateral foraminal compression, normal bilateral hips and normal strength, sensory and reflex findings. The claimant was diagnosed with L5-S1 five to six millimeter spondylolisthesis with spondylolysis and foraminal stenosis with positive discogram; and L4-5 disc degeneration with positive discogram. Fusion was recommended.

On 06/18/08 there was report of recent Bells Palsy and use of steroids. The claimant was noted to continue use of Darvocet, Robaxin and Neurontin. A presurgical psychiatric evaluation was conducted on 06/27/08 and there were no contraindications noted for surgery; however, the claimant was diagnosed with moderate depression.

On 07/01/08 the claimant remained essentially the same with extension noted to zero degrees. Upon undergoing presurgical evaluation on 07/08/08 the chest x-ray was suspicious of a mass and the claimant underwent chest CT and pulmonary evaluation. The claimant underwent bilateral L5-S1 laminectomy, foraminotomy and facetectomy; L4-5 right laminectomy, foraminotomy and facetectomy; reduction of L5-S1 spondylolisthesis; placement of six pedicle screws and two rods; and placement of iliac crest bone graft on 07/10/08. Intraoperatively a grade one to two spondylolisthesis was noted at L5-S1 with compression of nerve roots at both L4-5 and L5-S1; inability to make a right longitudinal incision; conjoined left L5 and S1 nerve roots; reduction of spondylolisthesis on radiographs; and confirmation of hardware on imaging. Postoperative radiographs on 07/25/08 noted good alignment and lateral fusion mass at L4-5 and L5-S1. The claimant continued use of medications. Repeat radiographs on 09/18/08 noted stability and good alignment with lateral fusion mass L4-S1. Physical examination on 10-09-08 noted guarding with excellent strength, intact sensation and equal reflexes. Dr. recommended CT evaluation of the lumbar surgery. On 11/19/08 Laboratory studies and a corset were recommended.

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

The records provided for this review do not provide a good indication for a CT scan. The request does not conform to the guidelines. There are no more recent film results available to assess for hardware failure or for fusion success. There is no documentation of an injury to suggest that there might be unrecognized failure of the hardware. There is no radiographic documentation of loss of alignment. The ODG recognizes that a CT scan is not the optimal radiographic procedure to assess for infection. There was no documentation provided to reflect concern on/or an unknown interval plain film regarding the status of the fusion or concern regarding hardware failure. Therefore, based on all of the above, the reviewer finds that medical necessity does not exist for CT scan of the lumbar spine, 72131.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates; Low Back-Computerized Tomography

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](#))

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)**