

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Lumbar CT w/o 72131

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

DO, Board Certified in Neurosurgery

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

Official Disability Guidelines-Treatment for Workers' Compensation, Chapter: Low Back

MRI lumbar spine 07/29/10

Clinical records Dr. 4/4/11, 1/17/11, 11/22/10, 10/11/10, 9/14/10, 8/18/10

Operative report 08/30/10

Radiographic report abdomen 09/01/10

Radiographic report KB 08/30/10

Radiographic report lumbar spine 10/11/10

Clinical records Dr. 8/17/10-6/17/11

CT lumbar spine 12/10/10

CT lumbar spine 03/04/11

Utilization review determination 06/21/11

Utilization review determination 07/05/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained injuries to his low back as a result of work related activity on xx/xx/xx. On this date he was reported to be lifting a bag of concrete and turned to throw it and developed significant low back pain radiating into the right lower extremity. The claimant underwent MRI of the lumbar spine on 07/29/10 which notes degenerative disc disease at L4-5 with a 2mm annular bulge and lateral recess stenosis bilaterally but no focal protrusion central canal stenosis or flattening of the exiting L4 nerve roots. There is facet arthropathy bilaterally at L5-S1 without foraminal encroachment. The remaining lumbar levels are reported to be unremarkable. The claimant subsequently was seen by Dr. on 08/17/10. It is noted his current medications are Norco, Cymbalta, Lyrica and Colospan. On physical examination he is reported to have 4/5 strength in the right hip flexors extensors and dorsiflexion. He is able to heel toe walk. Deep tendon reflexes were normal and symmetrical. He is opined to have low back pain with radiculopathy. He subsequently

was recommended to undergo surgical intervention on this date. The claimant was additionally being followed by Dr.

On 08/30/10 the claimant was taken to surgery and underwent L4-5 laminectomy decompression facetectomy at L4 on the left partial facetectomies at L4-5 bilaterally placement of interbody device at L4-5 interbody arthrodesis with auto and allograft posterolateral arthrodesis at L4-5 and instrumentation with pedicle screws at L4-5. Post-operatively the claimant is noted to have developed an ileus. He was subsequently discharged.

On 09/14/10 the claimant was seen in follow up by Dr. He reports decreased right leg pain but increased back pain. He is further complaining of right leg cramping and paresthesias and requests a single point cane. The claimant was referred for radiographs of the lumbar spine on 10/11/10. These studies not hardware to be in place with laminectomy defects. There's no evidence of hardware failure. The claimant is noted to have an interval fall in November 2010. On 12/10/10 he was referred for CT of the lumbar spine without contrast which notes post surgical changes at L4-5 with increased attenuation around the thecal sac and the bilateral proximal lateral recesses and in the left proximal neural foramen. There is non-specific decreased attenuation in the posterior paraspinal soft tissues midline at the posterior decompression bone defects. These are opined to be non-specific findings. Records indicate that the claimant was ultimately referred to physical therapy and continued to have back pain and tingling in his right lower extremity. His physical therapy was discontinued. He was recommended to undergo repeat CT of the lumbar spine. This study was performed on 03/04/11 and notes that the claimant is status post decompression posterior lumbar interbody fusion with no significant change in the CT appearance of the post-operative level. Records indicate that the claimant continued to be followed by pain management. Dr. notes that CT shows fusion mass posterolaterally and in the interbody space. He notes that there is no evidence of hardware loosening and he cannot say for sure the claimant has a solid fusion. A request was subsequently placed for repeat study. On 06/21/11 the request was reviewed by Dr. who notes that the claimant's current objective findings do not suggest a progression of symptoms and that the medical necessity for the request is not established. On 07/05/11 the request was reviewed by Dr. who notes that there was an adverse determination on the previous review and that there is a lack of documentation of progression of symptoms and failure of conservative treatment and again finds that the medical necessity of the request has not been substantiated.

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

The claimant has low back pain with reported radiation into the right lower extremity. The claimant was taken to surgery on 08/30/10 at which time he underwent decompression and interbody fusion at the L4-5 level as well as posterolateral arthrodesis. Post-operatively the claimant has had complaints of low back pain with subjective tingling in the right lower extremity. Since surgery the claimant has undergone two CTs of the lumbar spine the first being performed on 12/10/10 secondary to concerns regarding falls and the claimant's subjective complaints and the second performed on 03/04/11 again secondary to the claimant's subjective reports. The records as provided do not substantiate a progressive neurologic deficit that would warrant repeat imaging or repeat CT scan. There is not clear clinical evidence that the claimant has a new or progressive neurologic deficit. Serial radiographs do not suggest the development of a pseudoarthrosis. A repeat CT of the lumbar spine would not be clinically indicated or supported under Official Disability Guidelines. The reviewer finds there is not a medical necessity at this time for Repeat Lumbar CT w/o 72131.

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

ACOEM-AMERICA 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)