

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 26, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar CT scan

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

This physician is a Board Certified Orthopedic Surgeon with 43 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On, an MRI of the lumbar spine was performed. Impression: 1. At L4-L5 there is degenerative desiccation and bulging of the intervertebral discs with facet hypertrophy producing minimal to mild lateral recess and neural foraminal

stenosis. 2. At L5-S1 there is desiccation and bulging of the intervertebral discs with no focal protrusion, central spinal canal or neural foraminal stenosis as interpreted by M.D.

On December 9, 2002, an MRI of the lumbar spine was performed. Impression: 1. Left subarticular left lateral disc herniation protrusion L3-4 level. 2. Minimal retrolisthesis L4 with internal disc derangement desiccation and narrowing of the intervertebral disk with minimal bulging and central spinal canal stenosis. 3. L3-4 changes appear to be new findings as interpreted by M.D.

On January 31, 2002, a CT of the lumbar spine was performed. Impression: 1. L2-L4: Unremarkable. 2. L4-5: There appears to be contrast excreted out of the nucleus suggestive of annular tear. 3. L5-S1: Again noted contrast outside of the nucleus suggest rupture contained within the outer fibers of the annulus. Also there are degenerative changes of the visualized spine as interpreted by M.D.

On May 3, 2005, M.D. performed bilateral facet blocks at L4-5 and L5-S1.

On July 1, 2005, the claimant was evaluated by M.D. He continues to have low back pain in which medication does not allow him to work uninhibited. Left thigh diameter is 44.5 cm and the right 50cm. Positive straight leg raise. Impression: Lumbar facetogenic pain. 2. Lumbago. 3. Lumbar internal disc derangement. Therapy was again recommended and lumbar spine MRI.

On July 29, 2005, the claimant was re-evaluated by M.D. He stated his back pain has worsened and now extends to numbness of the medial aspect of the left thigh. An EMG was recommended.

On September 20, 2005, an MRI of the lumbar spine was performed. Impression: Multilevel spinal canal and neural foraminal stenosis at L3-S1.

On October 11, 2005, M.D. performed bilateral facet injections at L3-4, L4-5 and L5-S1.

On October 19, 2005, the claimant was re-evaluated by M.D. The lumbar facet blocks did not help. He has decreased sensation of the left medial thigh. Lumbar decompression was recommended.

On December 7, 2005, the claimant was re-evaluated by M.D. Lumbar surgery has not been approved. His condition continues to worsen. He has difficulty standing from a seated position. He has guarded and painful range of motion.

On February 20, 2006, the claimant was re-evaluated by M.D. Surgery has been approved. Medications only help to curb the edges of the pain.

On June 22, 2006, X-Rays of the lumbar spine was performed. Impression: 1. Posterior spinal fusion at L3-S1 level with satisfactory alignment and position of fixation components. 2. Normal alignment of the visualized lumbar vertebral bodies. No compression fractures. 3. Suggestion of laminectomies at L3, L4 and L5 as interpreted by M.D.

On June 29, 2006, the claimant underwent surgical intervention of the lumbar spine. Procedures: 1. Redo left L3-L4 hemilaminectomy-discectomy. 2. Right L3-4 hemilaminectomy. 3. Red left hemilaminectomy with re-exploraiton of the L5 nerve root. 4. Right L4-5 hemilaminectomy. 5. Left L5-S1 redo hemilaminectomy with reexploration of the left S1 nerve root. 6. Right L5-S1 hemilaminectomy. 7. Posterior lumbar fusion of L3 through S1. 8. Posterior lumbar instrumentation from L3 through S1. 9. Interbody fusion of L4-5 with a cage. 10. Interbody fusion of L5-S1 with a cage. 11. Intrathecal Duramorph spinal. 12. Dural tear repair. 13. Use of free muscle flap to augment the dural tear repair. 14. Bone allograft.

On July 14, 2006, the claimant was re-evaluated by M.D. He has lumbar decompression and fusion 3 weeks prior. He is able to stand from a sitting position in a guarded motion with the aid of a walker. Strength of the left EHL and anterior tibialis have improved. He still has decreased sensation of the left lower extremity. He has been fitted for a TLSO brace and bone stimulator. X-Rays: Two views of the lumbar spine demonstrate all the hardware to be intact, as well as the two distal intervertebral cages. The lateral gutters are well visualized with the bone graft as well. The remainder of the boney structures is unremarkable. Assessment: Lumbar spondylolisthesis, Lumbago, and Spinal canal Stenosis.

On August 16, 2006, the claimant was re-evaluated by M.D. He tries to be as active as possible and walks on a daily basis. He continues to have back pain and bilateral lower extremity symptoms. On the right he has pain that radiates along the lateral aspect of the thigh and lower leg, while on the left he continues to have the weakness and nearly left foot drop. X-Rays: Two views of the lumbar spine demonstrate the hardware to be in excellent location as the osteoblastic activity continues to improve along the intervertebral spaces and the lateral gutters. Fusion is still not complete. There is generalized osteopenia throughout with lumbar spondylosis. Assessment: Lumbar spondylolisthesis, Lumbago, and Spinal canal Stenosis. Assessment: Lumbar spondylolisthesis, Lumbago, and Spinal canal Stenosis.

On October 18, 2006, the claimant was re-evaluated by, M.D. He continues to wear his TLSO brace and bone stimulator which helped control his symptoms. He still has the continued need for medications. He complains of bilateral lower extremity cramping that wakes his up at night along the dorsal aspect of both feet and toes. X-Rays: Two views of the lumbar spine demonstrate progressions of the osteoblastic activity along the lateral gutters on the right greater than on the

left. There is also good alignment of the intervertebral spaces with fusion of the L4-5, but still some radiolucency along the L5-S1. There is no radiolucency along any of the screws. The remainder of the bony structure is unremarkable. Assessment: Lumbar spondylolisthesis, Lumbago, and Spinal canal Stenosis.

On November 20, 2006, the claimant was re-evaluated by M.D. X-rays: Two views of the lumbar spine demonstrate minimal radiolucency around the left sacral screw, although the other 7 screws are in excellent location, intact and fused. There is further progression of osteoblastic activity along the lateral gutters, as well as the intervertebral cages which are nearly completely fused at this time. The remainder of the bony structure demonstrates generalized lumbar spondylosis and osteopenia. Assessment: Lumbar spondylolisthesis, Lumbago, and Spinal Canal Stenosis.

On January 5, 2007, the claimant was re-evaluated by M.D. He has begun physical therapy and was quite difficult for him. There is a decreased strength of the left EHL and anterior tibialis, although it is improved from before. There is a positive left SLR test and a positive left Patrick's. X-Rays: Two views of the lumbar spine demonstrate the fusion to be complete at this point as there is no more radiolucency around any of the screws. There is full osteoblastic activity along the lateral gutters as well with lumbar spondylosis. The remainder of the bones structures is unremarkable. Assessment: Lumbar spondylolisthesis, Lumbago, and Spinal Canal Stenosis.

On February 7, 2007, the claimant was re-evaluated by M.D. The left anterior tibialis and EHL is much stronger. SLR test is negative. ROM of his back is still painful. X-Rays: Two views of the lumbar spine show he has a solid fusion. Assessment: Lumbar spondylolisthesis and Lumbar Spinal Canal Stenosis.

On March 9, 2007, the claimant was re-evaluated by, M.D. He has been attending physical therapy and recovering nicely. He suffered a fall at home due to balance loss secondary to weakness in his left leg. X-Rays: Two views of the lumbar spine demonstrate the hardware in excellent location without any radiolucency at any of the screws. The intervertebral cages are intact and in a good location as the fuse are complete. There is no evidence of fracture, dislocation, or subluxation with only generalized osteopenia throughout. Assessment: Lumbar spondylolisthesis, lumbago, lumbar internal disc derangement, and lumbar spinal canal stenosis.

On April 11, 2007, the claimant was re-evaluated by M.D. He no longer uses his cane to ambulate. However the lumbar pain still exacerbates intermittently with increased activity. There is tenderness of the paraspinous muscles in the lumbar sacral region, but there is no pain exacerbation in any direction. The lower extremities have a decreased sensation along the left medial and posterior thigh while there still remains a weakness of the left anterior tibialis and EHL compared to the right. There continues to be hyporeflexia of the left Achilles with a negative

SLR test. Assessment: Lumbar spondylolisthesis. Lumbago. Lumbar internal disc derangement. Lumbar spinal canal stenosis.

On June 13, 2007, the claimant was re-evaluated by M.D. He remains very active. He reports a constant struggle with pain and weakness along the left anterior and lateral thigh. There is decreased Achilles' reflex of the left foot when compared to the right with a negative SLR bilaterally. Assessment: Lumbar spondylolisthesis. Lumbago. Lumbar internal disc derangement. Lumbar spinal canal stenosis.

On June 29, 2007, the claimant was re-evaluated by M.D. The motor function is intact and has a positive left SLR test, but a negative bilateral Patrick's. There is a decreased left Achilles reflex. X-Rays: Two views of the lumbar spine demonstrate the hardware to be in excellent location, as well as the intervertebral spacers. The fusion is complete and intact, as there is no evidence of fracture, dislocation, or subluxation. Assessment: Lumbar spondylolisthesis. Lumbago. Lumbar internal disc derangement. Lumbar spinal canal stenosis.

On August 14, 2007, the claimant was re-evaluated by M.D. His lumbar pain has decreased from a 7/10 to 4/10. The left leg numbness is still there however it is decreasing. He suffers from partial urinary incontinence. Assessment: Lumbar spondylolisthesis. Lumbago. Lumbar spinal canal stenosis.

On December 28, 2007, the claimant was re-evaluated by M.D. He no longer has urinary problems. He is prescribed Torolac, Lyrica, Soma, Relafen and Lidoderm patches.

On April 28, 2008, the claimant was re-evaluated by M.D. He has increasing and constant lumbar pain. His medication has not been effective for him. He would like a facet block. Assessment: Lumbar spondylolisthesis. Lumbago. Lumbar spinal canal stenosis.

On July 16, 2008, the claimant was re-evaluated by M.D. He does not report and lower extremity radicular problems. His pain is 5 out of 10. Assessment: Lumbar spondylolisthesis. Lumbar spinal canal stenosis.

On August 18, 2008, the claimant was re-evaluated by M.D. He now reports radicular symptoms of the right leg and have been present for about a month. A Lumbar CT scan was recommended. X-Rays: Two views of the lumbar spine demonstrate the hardware to be in excellent location as well as the intervertebral cages. There is asymmetrical fusion along the lateral gutters, the right greater than the left. The intervertebral cages are also intact. There is generalized osteopenia and lumbar spondylosis. imaging on flexion and extension demonstrates a Grade I L4-5 spondylolisthesis. It is also notable to have asymmetrical fusion of the lateral gutters. There is a 4mm shift at the L4-5. There is generalized osteopenia with lumbar spondylosis and the remainder of

the boney structures is unremarkable and intact. Assessment: Lumbar spondylolisthesis. Lumbar spinal canal stenosis. Lumbago.

On September 19, 2008, the claimant was re-evaluated by M.D. X-Rays: A lumbar CT scan done on 9/2/08 reveals a solid posterior fusion from L3-L5. He also has a solid anterior fusion of L4-5 and L5-S1.

On November 21, 2008, the claimant was re-evaluated by M.D. The lumbar spine has limited motion also that exacerbates on the extension. The lower extremities are motor intact with a decreased sensation along the left medial thigh. There is a positive bilateral SRL test, but negative bilateral Patrick's. The DTRs are symmetrical bilaterally. Assessment: Lumbar spondylolisthesis and lumbago.

On February 20, 2009, the claimant was re-evaluated by, M.D. Any kind of movement there is a pulling, shooting pain that radiates through the lumbar region. He still has generalized numbness of the thigh and lower leg.

On April 3, 2009, the claimant was re-evaluated by M.D. There is tenderness of the paraspinal muscles down to the lumbar sacral region. The lower extremities are motor intact although there is a decreased sensation along the left anterior and medial thigh, as well as the anterior and medial lower leg. There is a positive left SLR although the deep tendon reflexes are symmetrical bilaterally. Assessment: Lumbar spondylolisthesis, lumbar radiculopathy, and lumbago.

On October 23, 2009, the claimant was re-evaluated by, M.D. His symptoms have remained unchanged. He had an accident where he fell on his buttocks causing an increase in lumbar pain. His insurance company has suspended his medications causing his pain to become worse. X-Rays: Four views of the lumbar spine demonstrate the hardware to be in excellent location as well as the intervertebral cages of the L4-5 and L5-S1. The fusion is complete and intact. There does not appear to be any changes secondary to the fall. There is generalized osteopenia and lumbar spondylosis. Assessment: Lumbar spondylolisthesis, lumbar radiculopathy, and lumbago.

On July 23, 2010, the claimant was re-evaluated by M.D. He still has not gotten approval of his medications and his pain can escalate to 8/10. He has bilateral radicular symptoms of the lower extremities and burning sensation on the plantar aspect of the feet. Left thigh diameter at 6 inches from the knee measures 41 cm. The right thigh diameter at 6 inches from the knee measures 45 cm. Assessment: Lumbago, Lumbar spondylosis, and Lumbar spondylolisthesis.

On August 23, 2010, the claimant was re-evaluated by M.D. The left EHL are 4/5 strength. There is increased sensation on the left anterior thigh. X-Rays: A

lateral flexion and extension lumbar x-ray reveals that the hardware is intact without loosening from L3-S1. There is good incorporation of bone at the L4-5 and L5-S1 disks. There is a dynamic retrolisthesis of L2-3. Assessment: Lumbago and Lumbar spondylolisthesis.

On November 29, 2010, an MRI of the lumbar spine was performed. Impression: 1. Laminectomy with rod and pedicle screw fixation L2-S1 with wide patency of the canal and foramina through the operated levels. Interbody fusion grafts are present L4-L5 and L5-S1 and are in good position. Minimal enhancing epidural fibrosis is seen L4-L5. 2. L2-L3 Hypertrophic changes without significant canal or foraminal stenosis as interpreted by M>D.

On December 13, 2010, the claimant was re-evaluated by M.D. He has severe low back pain which radiates from the thoracic area to lower back as well as into the buttock region. A CT scan was recommended to see if he is fused from L2 through S1.

On December 30, 2010, M.D., a physical medicine and rehabilitation physician performed a utilization review on the claimant. Rationale for denial: The patient has undergone recent x-rays and an updated MRI on the lumbar spine. Consequently, it is not felt that a lumbar CT scan would provide significant diagnostic value. Additionally, comparison findings on August 2,3 2010 versus date December 18, 2010 demonstrates no progressive neurological deficits as the patients clinical findings are similar. Therefore it is not certified.

On February 3 2011, M.D., an orthopedic surgeon performed a utilization review on the claimant. Rationale for denial: Imaging studies appear to depict the fused area appropriately noting good bone incorporation and no motion with flexion-extension. Information from a repeat CT scan would be unlikely to provide additional information. Therefore it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, the claimant sustained an injury to the lumbar spine.

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

I agree that the CT of the lumbar spine is not warranted.

Dr. ordered a CT of the lumbar spine on December 13, 2010 to specifically evaluate the fusion mass from L2 through S1. The CT was denied by separate utilization reviews of Dr. and Dr..

In June 2006, the claimant underwent a posterior lumbar fusion L3-S1, anterior interbody cages at L4-5 and L5-S1, and redo decompression. The claimant's fusion mass was confirmed to be healed and solid, both anteriorly and posteriorly, according to a lumbar CT scan dated September 2, 2008.

All plain x-ray studies from that point onward indicate intact hardware without loosening through the instrumented lumbar spine. There is no gross motion from L3-S1 on flexion and extension views of Aug 23, 2010, consistent with solid hardware and a solid fusion. Based on ODG criteria, a lumbar CT is not indicated because a successful fusion is confirmed by the plain x-rays.

Furthermore, the MRI of November 29, 2010 documents appropriate positioning of the interbody cages at L4-5 and L5-S1. There is no evident of hardware failure. The MRI also confirms that the decompression is appropriate from L2-S1, both centrally and at the level of the neuroforamina.

From my perspective, there is no reason to expose the claimant to additional radiation when there is a previous CT confirming bone healing through the instrumented region. Furthermore, there is no reason to suspect that there is hardware failure or incomplete decompression. Therefore, the previous decisions are upheld.

ODG:

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)