

CT Lumbar Spine

CPT: 72131, 72132, 72133

IMPORTANT NOTES

- For most indications MRI is the preferred exam

Red Flags Disregard any requirement for prior management if any of the following are part of the clinical history:

- Abnormal CBC, Sed Rate, etc
- Bladder and Bowel dysfunction
- Fever
- Cancer, History of
- Immunocompromised state
- IV drug use
- Major weakness of a limb
- Pain increased at rest
- Saddle anesthesia
- Trauma
- Unexplained weight loss
- Urinary tract infections

The requirement for Medical or Conservative Management prior to imaging is satisfied if the following are met:

1. Nonsteroidal anti-inflammatory drugs for at least four weeks (Requirement is waived if NSAIDS are not tolerated or contraindicated, or if condition worsens while under treatment.)
2. Activity modification or physical therapy if appropriate

1 Major Symptom or Complaint presented as primary indication

- 1.1 Bilateral radiculopathy
- 1.2 Bladder dysfunction
- 1.3 Bowel incontinence
- 1.4 Brachial Plexus Pathology (Plexopathy)
 - 1.4.1 History of Breast or Lung cancer
 - 1.4.2 History of radiation therapy to the chest, breast or axilla
 - 1.4.3 Numbness
 - 1.4.4 Paresthesias
 - 1.4.5 Radiating pain
 - 1.4.6 Weakness of upper extremity

References:

1. Devin K. Binder, M.D., Ph.D.; Justin S. Smith, M.D., Ph.D.; Nicholas M. Barbaro, M.D Primary Brachial Plexus Tumors: Imaging, Surgical, and Pathological Findings in 25 Patients Neurosurgical Focus Medscape Radiology accessed 12/28/08
2. Bowen B, Seidenwurm DJ, Davis P, et al, Expert Panel on Neurologic Imaging, American College of Radiology, Appropriateness Criteria, Plexopathy, accessed at http://www.acr.org/SecondaryMainMenuCategories/quality_safety/app_criteria/pdf/ExpertPanelonNeurologicImaging/PlexopathyDoc12.asp 12/28/08
3. ACR Appropriateness Criteria Plexopathy p10 Accessed 12/28/08

1.5 Burning sensations (dysesthesias)

- 1.5.1 Failed conservative management
- 1.6 Clumsiness, increasing with time

1.7 Erectile dysfunction

NOTE

"Imaging studies are rarely performed, except in situations in which pelvic trauma or surgery has occurred." * Nonetheless, if the requirements for CAUDA EQUINA SYNDROME are met CT may be authorized

1.7.1 Cauda Equina Syndrome Either

1.7.1.1 Complaints, ANY, Conservative Management REQUIRED

1.7.1.1.1 Leg weakness

1.7.1.1.2 Low-back pain

1.7.1.1.3 Sciatica

1.7.1.2 Findings, ANY, these are RED FLAGS, Conservative Management NOT REQUIRED

1.7.1.2.1 Bowel and bladder dysfunction

1.7.1.2.2 Decreased rectal tone and perineal reflexes

1.7.1.2.3 Saddle anesthesia

References:

1. Stanley A Brosman, MD, Erectile Dysfunction: Differential Diagnoses & Workup eMedicine Specialties > Urology > Erectile Dysfunction, Premature Ejaculation, and Sexual Disorders Updated: Jan 15, 2008 Accessed Jan 2, 2009
2. Levin, Kerry; Lumbar Spinal Stenosis, UpToDate 15.2 accessed 07/09/07
3. Tintinalli's Emergency Medicine A Comprehensive Study Guide, 6th Edition Judith E. Tintinalli, MD, MS, Gabor D. Kelen, MD, J. Stephan Stapczynski, MD, O. John Ma, MD and David M. Cline, MD Eds. The American College of Emergency Physicians Section 22: Trauma > Chapter 256. Spinal Cord Injuries > Clinical Features > Spinal Cord Lesions >

1.8 Gait disturbances

1.9 Loss of bowel or bladder control

1.10 Numbness, in nerve root distribution

1.10.1 Failed conservative management

1.11 Pain, local to spine or radiating in root pattern [One]

1.11.1 Known malignancy elsewhere RED FLAG

1.11.2 No RED FLAGS, Failed conservative management

1.11.3 Suspected epidural abscess

1.11.3.1 AIDS

1.11.3.2 ESR elevated

1.11.3.3 Fever

1.11.3.4 Immunosuppressed

1.11.3.5 White count elevated

1.12 Paralysis

1.13 Sensory abnormality confirmed by examination

1.13.1 Myelopathy suspected

1.13.2 Radiculopathy or disc disease suspected. Failed conservative management

1.14 Severe pain, not responding to opiates or worsening, RED FLAG

1.15 Shooting pain, in nerve root distribution

1.15.1 Radiculopathy or disc disease suspected. Failed conservative management

1.16 Tingling sensations (paresthesias)

1.16.1 Radiculopathy or disc disease suspected. Failed conservative management

1.17 Weakness, in nerve root distribution

1.17.1 Failed Conservative Management

2 Working Diagnosis or Rule Out presented as primary indication

2.1 Bilateral radiculopathy

2.2 Epidural abscess, Suspected BOTH

2.2.1 Clinical Findings ONE

2.2.1.1 AIDS

2.2.1.2 ESR Elevated

2.2.1.3 Fever

2.2.1.4 Immunosuppressed

2.2.1.5 Infection elsewhere

2.2.1.6 Positive blood culture

2.2.1.7 Recent spinal surgery or procedure

2.2.1.8 WBC elevated

2.2.2 Symptoms ONE

2.2.2.1 Loss of bowel or bladder control

2.2.2.2 Muscle weakness

2.2.2.3 Pain, local to spine or radiating in root pattern

2.2.2.4 Paralysis

2.2.2.5 Sensory abnormality confirmed by examination

2.2.2.6 Tenderness over spine

2.3 Metastasis Suspected, Known malignancy elsewhere

2.3.1 Focal Pain

2.3.2 Neurologic findings

2.3.3 Suspicious findings on other imaging

2.4 Myelopathy Suspected MRI PREFERRED Lumbar myelopathy is evaluated by performing a Thoracic spine exam because the spinal cord ends at the approximate level of T12 or L1.

2.4.1 Bilateral radiculopathy

2.4.1.1 Failed Conservative Management AND ONE

2.4.1.1.1 Atrophy of upper extremity musculature

2.4.1.1.2 Burning sensations (dysesthesias)

2.4.1.1.3 Hyporeflexia

2.4.1.1.4 Numbness, in nerve root distribution

2.4.1.1.5 Shooting pain, in nerve root distribution

2.4.1.1.6 Tingling sensations (paresthesias),

2.4.1.1.7 Weakness, in nerve root distribution

2.4.2 Bladder dysfunction

2.4.3 Bowel incontinence

2.4.4 Clumsiness, increasing with time

2.4.5 Gait disturbances

2.4.6 Sensory abnormality objectively observed

2.5 Neurogenic Claudication SEE Radiculopathy

2.6 Osteomyelitis suspected MRI Preferred

2.6.1 Pain or Fever AND One

2.6.1.1 C reactive Protein elevated

2.6.1.2 Elevated ESR

2.6.1.3 Fever

2.6.1.4 Leukocytosis

2.6.1.5 Positive Blood Cultures

References

1. Parsonnet Jeffrey, "Chapter 120. Osteomyelitis" (Chapter). Fauci AS, Braunwald E, Kasper DL, Hauser SL, Longo DL, Jameson JL, Loscalzo J: Harrison's Principles of Internal Medicine, 17th Edition: <http://www.accessmedicine.com/content.aspx?aID=2893649>
2. Alok Kapoor, Stephanie Page, Michael LaValley, Daniel R. Gale, and David T. Felson Magnetic Resonance Imaging for Diagnosing Foot Osteomyelitis: A Meta-analysis Arch Intern Med, Jan 2007; 167: 125 – 132
3. J. Herman Kan, Melissa A. Hilmes, Jeffrey E. Martus, Chang Yu, and Marta Hernanz-Schulman Value of MRI After Recent Diagnostic or Surgical Intervention in Children with Suspected Osteomyelitis Am. J. Roentgenol., Nov 2008; 191: 1595 – 1600
4. Kuo-Chen Lee, Yi-Ting Tsai, Chih-Yuan Lin, and Chien-Sung Tsai Vertebral osteomyelitis combined streptococcal viridans endocarditis Eur. J. Cardiothorac. Surg., Jan 2003; 23: 125
5. D Allen, S Ng, K Beaton, and D Taussig Sternal osteomyelitis caused by Aspergillus fumigatus in a patient with previously treated Hodgkin's disease J. Clin. Pathol., Aug 2002; 55: 616 – 618
6. M Ida, H Watanabe, A Tetsumura, and T Kurabayashi CT findings as a significant predictive factor for the curability of mandibular osteomyelitis: multivariate analysis Dentomaxillofac. Radiol., Mar 2005; 34: 86 – 90
7. Jyri K. Koort, Tatu J. Mäkinen, Juhani Knuuti, Jari Jalava, and Hannu T. Aro Comparative 18F-FDG PET of Experimental Staphylococcus aureus Osteomyelitis and Normal Bone Healing J. Nucl. Med., Aug 2004; 45: 1406 – 1411.
8. Susan A. Connolly, Leonard P. Connolly, Laura A. Drubach, David Zurakowski, and Diego Jaramillo MRI for Detection of Abscess in Acute Osteomyelitis of the Pelvis in Children Am. J. Roentgenol., Oct 2007; 189: 867 – 872

2.7 Radiculopathy or Spinal Stenosis

2.7.1 Failed Conservative Management NO Red Flags ANY ONE

2.7.1.1 Atrophy of musculature

2.7.1.2 Burning sensations (dysesthesias)

2.7.1.3 Numbness, in nerve root distribution

2.7.1.4 Positive Straight Leg Raising (SLR) test

2.7.1.5 Shooting pain, in nerve root distribution

2.7.1.6 Tingling sensations (paresthesias),

2.7.1.7 Weakness, in nerve root distribution

2.8 Spinal Stenosis SEE Radiculopathy

3 Abnormal Physical Exam Finding presented as primary indication

3.1 Sacral Plexus Pathology (Plexopathy)

3.1.1 History of Breast or Lung cancer

3.1.2 History of radiation therapy to the chest, breast or axilla

3.1.3 Numbness

3.1.4 Paresthesias

3.1.5 Radiating pain

3.1.6 Weakness of upper extremity

References:

1. Devin K. Binder, M.D., Ph.D.; Justin S. Smith, M.D., Ph.D.; Nicholas M. Barbaro, M.D Primary Brachial Plexus Tumors: Imaging, Surgical, and Pathological Findings in 25 Patients Neurosurgical Focus Medscape Radiology accessed 12/28/08
2. Bowen B, Seidenwurm DJ, Davis P, et al, Expert Panel on Neurologic Imaging, American College of Radiology, Appropriateness Criteria, Plexopathy, accessed at http://www.acr.org/SecondaryMainMenuCategories/quality_safety/app_criteria/pdf/ExpertPanelonNeurologicImaging/PlexopathyDoc12.asp 12/28/08
3. ACR Appropriateness Criteria Plexopathy p10 Accessed 12/28/08

3.2 Cauda Equina Syndrome Either

3.2.1 Complaints, ANY, Conservative Management REQUIRED

3.2.1.1 Leg weakness

3.2.1.2 Low-back pain

3.2.1.3 Sciatica

3.2.2 Findings, ANY, these are RED FLAGS, Conservative Management NOT REQUIRED

3.2.2.1 Bowel and bladder dysfunction

3.2.2.2 Decreased rectal tone and perineal reflexes

3.2.2.3 Saddle anesthesia

3.2.2.4 Known Malignancy and

3.2.2.4.1 Leg weakness

3.2.2.4.2 Low-back pain

3.2.2.4.3 Sciatica

References:

1. Carlos A. Bagley, M.D., Ziya L. Gokaslan, M.D., Cauda Equina Syndrome Caused by Primary and Metastatic Neoplasms Posted 07/02/2004 Neurosurg Focus 16(6), 2004. © 2004 American Association of Neurological Surgeons
2. Levin, Kerry; Lumbar Spinal Stenosis, UpToDate 15.2 accessed 07/09/07
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4. Cauda equina syndrome Chris Lavy, Andrew James, James Wilson-MacDonald, Jeremy Fairbank
5. BMJ 2009;338:b936, doi: 10.1136/bmj.b936 (Published 31 March 2009)

3.3 Gait disturbances

3.4 Hyporeflexia

3.4.1 Radiculopathy or disc disease suspected. Failed conservative management

3.5 Numbness, in nerve root distribution

3.5.1 Failed conservative management

3.6 Sensory abnormality confirmed by examination

3.6.1 Myelopathy suspected

3.6.2 Radiculopathy or disc disease suspected. Failed conservative management

3.7 Straight Leg Raising test positive, conservative management failed

4 Abnormal Lab or Imaging presented as primary indication

4.1 Fracture seen or suspected on recent x-ray

5 Significant Prior Medical History presented as primary indication

5.1 Epidural abscess, Known

5.1.1 After treatment

5.1.1.1 Interval Follow up

5.1.1.2 Recurrent or worsening symptoms

5.2 Infection or abscess, after treatment

5.3 Management and assessment of spinal injury

5.4 Meningocele or Myelomeningocele

5.5 Multiple Sclerosis Because the spinal cord ends above the lumbar spine imaging for MS is not generally appropriate. Send for physician review

References:

1. Adams and Victor's Neurology > Part 4. Major Categories of Neurologic Disease > Chapter 36. Multiple Sclerosis and Allied Demyelinative Diseases > Multiple Sclerosis > Pathologic Findings
2. Multiple sclerosis. T2-weighted MRIs demonstrating multiple plaques in the periventricular white matter (left), emanating radially from the corpus callosum ("Dawson fingers") (middle), and cervical spinal cord (right). The radial orientation and periventricular location of cerebral lesions is typical of the disease.

5.6 Osteomyelitis Known MRI PREFERRED

5.6.1 Interval follow up during and after treatment

5.6.2 Preoperative

5.6.3 Worsening clinical situation

References:

1. Parsonnet Jeffrey, "Chapter 120. Osteomyelitis" (Chapter). Fauci AS, Braunwald E, Kasper DL, Hauser SL, Longo DL, Jameson JL, Loscalzo J: Harrison's Principles of Internal Medicine, 17th Edition: <http://www.accessmedicine.com/content.aspx?aID=2893649>.
2. Alok Kapoor, Stephanie Page, Michael LaValley, Daniel R. Gale, and David T. Felson Magnetic Resonance Imaging for Diagnosing Foot Osteomyelitis: A Meta-analysis Arch Intern Med, Jan 2007; 167: 125 – 132.
3. J. Herman Kan, Melissa A. Hilmes, Jeffrey E. Martus, Chang Yu, and Marta Hernanz-Schulman Value of MRI After Recent Diagnostic or Surgical Intervention in Children with Suspected Osteomyelitis Am. J. Roentgenol., Nov 2008; 191: 1595 – 1600.
4. Kuo-Chen Lee, Yi-Ting Tsai, Chih-Yuan Lin, and Chien-Sung Tsai Vertebral osteomyelitis combined streptococcal viridans endocarditis Eur. J. Cardiothorac. Surg., Jan 2003; 23: 125.
5. D Allen, S Ng, K Beaton, and D Taussig Sternal osteomyelitis caused by Aspergillus fumigatus in a patient with previously treated Hodgkin's disease J. Clin. Pathol., Aug 2002; 55: 616 – 618.
6. M Ida, H Watanabe, A Tetsumura, and T Kurabayashi CT findings as a significant predictive factor for the curability of mandibular osteomyelitis: multivariate analysis Dentomaxillofac. Radiol., Mar 2005; 34: 86 – 90.
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5.7 Prior to Surgical Intervention, as a road map for the surgeon

5.8 Scoliosis

5.8.1 Prior to corrective surgery

5.9 Trauma

5.9.1 Abnormal or nondiagnostic prior x-ray

5.9.2 Cauda Equina Syndrome after injury ANY

5.9.2.1 Bowel and bladder dysfunction

5.9.2.2 Decreased rectal tone and perineal reflexes

5.9.2.3 Leg weakness

5.9.2.4 Low-back pain

5.9.2.5 Saddle anesthesia

5.9.2.6 Sciatica

5.9.2.7 Weakness, in nerve root distribution

5.9.2.7.1 Radiculopathy or disc disease suspected. Failed conservative management

5.9.3 Meningocele or Myelomeningocele

5.9.3.1 Myelomeningocele is protrusion of nerve roots or cord elements along with the meninges. It occurs at least ten times more often than simple meningocele and always causes some degree of neurologic deficit.

5.9.3.2 Meningocele consists of herniation of the meninges through a spina bifida without abnormality of the spinal cord or nerve roots. Neurologic function is usually preserved in these patients.

Reference:

- Gerard M. Doherty and Lawrence W. Way CURRENT Surgical Diagnosis & Treatment, 12th Edition Chapter 37. Neurosurgery & Surgery of the Pituitary Mitchel S. Berger, MD Copyright © 2006 by The McGraw-Hill Companies, Inc. Accessed via Access Medicine 1/05/09

5.9.4 Midline spinal tenderness

5.9.5 New onset of neurologic findings

References:

1. A Gardner, S Grannum and KM Porter Cervical spine trauma Trauma [London] 2005; 7: 109-121
2. American College of Surgeons Committee on Trauma. 1997. Advanced trauma life support for doctors.
3. British Trauma Society. 2002. Guidelines for initial management and assessment of spinal injury. Injury, Int J Care Injured 34: 405-25.
4. Principles of Critical Care, 3rd Edition Copyright © 2005, 1998, 1992 by The McGraw-Hill Companies Jesse B. Hall, Gregory A. Schmidt, Lawrence D.H. Wood Part X. The Surgical Patient; Chapter 94. Spine Injuries; G. E. Johnson