



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/10/07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The services under dispute include the following CPT codes: 20931, 20937, 22612, 22630, 22842, 22851, 63047, 99223 and 77002.

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

The reviewing physician is a medical doctor who is board certified in orthopedic surgery and has been practicing for greater than 15 years.

**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)

The reviewer agrees with the previous adverse determination regarding all services under review.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: the patient, URA and requesting provider.

These records consist of the following from the patient: 9/25/07 to 10/11/07 notes, 9/25/07 and 10/3/07 denial letters and 9/14/07 lumbar discogram.

Records from the provider (in addition to any previously mentioned records) 2/23/07 physical exam report, treatment notes and addendums from 3/13/07 to 9/25/07, 6/19/06 MRI lumbar and 5/5/06 thoracic MRI.

Records from the carrier:(in addition to any previously mentioned records) preauth request form (without apparent date) and MD note 2/15/07.

We did NOT receive a copy of the ODG Guidelines from Carrier/URA.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This case concerns a female with lumbar and right/left leg pain after heavy lifting injury. She has been unable to work since 7/31/06 because of back pain. No weakness in either lower extremity. Conservative care consisting of physical therapy, chiropractic, Lumbar ESI's offered no long term relief. Neurologic exam revealed no localizing abnormalities. MRI 6/19/06 revealed L5-S1 disc desiccation and central to left protrusion and facet hypertrophy, L4-L5 disc bulging and facet effusions at L3-L4 and L4-L5. Discography response of only L5- S1 (no control level) was recorded by the radiologist as pressure, no typical pain, although the patient described the procedure later a painful. Patient has not been through intensive spinal rehabilitation or intensive home exercise program according to the records provided.

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

The ODG states, in cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. Until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." It appears that workers' compensation populations require particular scrutiny when being considered for fusion for chronic low back pain, as there is evidence of poorer outcomes in subgroups of patients who were receiving compensation or involved in litigation. (Fritzell-Spine, 2001) (Harris-JAMA, 2005) (Maghout-Juratli, 2006) (Atlas, 2006) Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield, 2002) While not recommended above,

if a decision is made to use discography anyway, the following criteria should apply:

- o Back pain of at least 3 months duration
- o Failure of recommended conservative treatment including active physical therapy
- o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)
  
- o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided)
- o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) (Carragee, 2006) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria.

There is no proven presence of surgical lesion (discography not described as concordant or even painful by radiologist). Procedure is not medically indicated or necessary as she does not meet the ODG criteria for this procedure at this time.

**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)