

Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 16, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar discogram at L3-4, L4-5, L5-S1 with post-discogram CT

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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)

Per the Official Disability Guidelines, a discogram is indicated if it is "intended as a screen for surgery." The patient was seen by Dr. on 09/25/07. At that office visit, he discussed a possible disc replacement based on discogram results. Per the Official Disability Guidelines, disc replacement is "not recommended at this time for either degenerative disc disease or mechanical low back pain."

Therefore, if a disc replacement is not considered appropriate per the Official Disability Guidelines, the Lumbar discogram at L3-4, L4-5, L5-S1 with post-discogram CT would not be considered medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/12/07, 11/20/07
ODG Physical Therapy Guidelines
ODG TWC Low Back Procedure Summary
MD, Operative Reports, 7/5/07, 1/5/06, 10/19/05,
MD, Notes, 11/6/07, 8/1/07, 6/20/07, 12/12/05, 11/9/05, 10/12/05, 9/7/05
MRI Lumbar Spine, 6/6/07
Doctors Notes, 10/26/07
9/25/07
Physical Therapy Prescription, 6/30/07
PTA, 6/28/07
PTA, 6/25/07
PT, 6/18/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has bilateral low back pain that will occasionally radiate into the bilateral lower extremities. He has undergone epidural steroid injections for this pain. Because he has not been responding to current treatments, he was evaluated by a neurosurgeon, Dr. on 09/25/07. At that office visit, Dr. recommended a disc replacement with "Synthes ProDisc." Dr. recommended that the patient be referred back to him if the patient decided that he wanted to receive the disc replacement. There have been no notes stating that the patient has actually requested to receive this procedure. There is an office visit note with Dr. on 11/06/07 where a lumbar discogram is requested.

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

Per the Official Disability Guidelines, in order for a discogram to be considered an appropriate procedure, the discogram should be used "as a screen for surgery." As stated above, Dr., a neurosurgeon, recommended a disc replacement. The Official Disability Guidelines do not recommend a disc replacement "at this time for degenerative disc disease or mechanical low back pain." In addition, the Official Disability Guidelines state that "radiculopathy is an exclusion criterion for the FDA studies on lumbar disc replacement." Based on this patient's history which consists of radiculopathy, he would not be a candidate for this surgery. Since this surgery is not appropriate per the Official Disability Guidelines, a discogram is not indicated at this time.

In conclusion, the reviewer finds that the Lumbar discogram at L3-4, L4-5, L5-S1 with post-discogram CT is not medically necessary.

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)