

I-Decisions, Inc.

An Independent Review Organization

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Amended Notice of Independent Review Decision

DATE OF REVIEW: 04/01/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical discogram with post discogram CT scan

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

M.D., Board Certified Orthopedic Surgeon

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)

Upon independent review the reviewer finds that the requested Cervical discogram with post discogram CT scan is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Adverse Determination letters, 02/28/08 and 02/21/08
2. Dr. records, 02/19/08
3. D.C., 03/08/08, 02/19/08, 01/17/08, 12/13/07, 09/13/07, 08/02/07
4. M.D., electrodiagnostic study results, 02/07/08
5. M.D., 01/28/08
6. Radiology report, 01/28/08

7. History and physical, 01/28/08
8. Consultation, 01/28/08
9. Dr., 03/06/08
10. Cervical myelogram and CT scan, 04/13/07
11. Carrier's letter to IRO, 03/24/08
12. ODG Guidelines and Treatment Guidelines
13. Dr. consultation, 07/16/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old female with date of injury xx/xx/xx. She has had what appears to be three previous cervical surgeries, an initial surgery followed by an instrumented C4/C5 fusion and removal of hardware, apparently. The medical records show evidence of degeneration above and below the fusion at C3/C4 and C5/C6. She has complaints, which are neck pain and some upper extremity pain and tingling. She has had a myelographic CT scan, which documented postoperative changes. There has been discussion of a chronic pain management program and spinal cord stimulation. An EMG/NCV study was considered and performed, which showed evidence of carpal tunnel syndrome but no cervical radiculopathy. There is a request for a multilevel discogram, which apparently is to determine if the adjacent motion segments are painful or not.

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

Based upon the medical records provided, there is no indication for the requested CT discogram of the cervical spine other than to determine whether the degenerative levels may or may not be painful. However, there is no indication of instability noted in the records, and the other investigative procedures such as CT myelogram do not evidence abnormalities that in any usual way would indicate necessity for discography. It would appear from the records that discography is being used as a primary diagnostic device rather than a confirmatory one. Based upon the ODG Guidelines utilized in this review, while discography is generally not recommended, the patient's selected criteria for discography, if it is to be performed, requires failure of conservative methods of treatment and satisfactory results of psychosocial assessment, the patient should be a candidate based upon imaging studies, and the patient should be aware of risks and benefits from both discography and from surgery. When these are combined with North American Spine Society Guidelines for Utilization of Provocative Discography, this patient does not meet the above criteria nor the confirmative criteria of previous abnormal imaging studies. Furthermore, a three-level fusion is clearly contemplated in this patient. The ODG Guidelines for cervical fusion make note of the fact that cervical fusion for degenerative disease resulting in actual neck pain and no radiculopathy remains controversial, and conservative therapy remains the treatment of choice unless there is evidence of instability. With this in mind, the reviewer upholds the previous adverse determination.

**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)**