



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 8/11/08

**IRO CASE #:**

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

The services under review include a Fluoroguide for spine injection (77003), CT lumbar spine w/o dye (72131), CT lumbar spine w/o and with dye (72133), X-ray of lower spine disk (72295) and 3D render w/o postprocess (76376).

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

The reviewer is a Medical Doctor who is a board certified orthopedic surgeon and has been practicing in this area 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 in all its parts.

We did not receive the ODG Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This worker was injured on xx/xx/xx as the result of falling of a fence injuring his lumbar spine and his knee. He had a surgical repair of the knee in January of 2007. He has been treated conservatively with the above exception. Examination of 4/18/08 by Dr. reveals left 4/5 EHL strength and numbness along left L2, L4 and S1 dermatomal distributions.

According to Dr. "patient has responded moderately well, but for short periods of time, to epidural blocks. We remain concerned about the significant disc resorption he has at L5/S1 and the possibility of Discogenic pain. The patient is a

candidate for surgical intervention. We need to determine if that could just be a simple laminectomy/discectomy versus a fusion procedure and we need to rule out adjacent level disease.”

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

The indications for a discogram are noted in the ODG. While not recommended by ODG, if a decision is made to use discography anyway, the following criteria should apply:

- o Back pain of at least 3 months duration (this is met)
- o Failure of recommended conservative treatment including active physical therapy (this is met by Dr.'s documentation of 11/30/07)
- 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) (this is met by the 6/15/07 MRI indicating 2 levels of DDD)
- 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) (this is met on 5/21/08)
- 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. (This is met as per Dr.'s documentation of 4/18/08)
- o Briefed on potential risks and benefits from discography and surgery (This is met based upon documentation)
- o Single level testing (with control) (Colorado, 2001) (This criterion is NOT met as Dr. is requesting a 3 level testing while a 2 level testing is considered the standard per the ODG)
- o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification (This criterion does not apply to this patient as he has not had prior lumbar surgery)

Due to all of the criteria not being met, the reviewer agrees with the previous non-certification of this procedure based upon the documentation provided.

**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)**