

Notice of Independent Review Decision
AMENDED REPORT
Date correction

DATE OF REVIEW: 12/17/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

L5/S1 IDET.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.O., duly licensed in the State of Texas, Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine, with over twenty years of active experience in the practice of Pain Management

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
			<i>Prosp.</i>						<i>Upheld</i>

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial 11/05 & 11/19/08, including ODG criteria for denial
3. MRI 04/15/08 and CT 10/21/08
4. Operative report 08/28/08
5. Progress note 10/29/08
6. Physician orders 10/30/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This claimant injured his lower back while lifting pallets on xx/xx/xx. The claimant had lumbar MRI scan performed on 04/15/08, which demonstrated "slight disc bulge" only at L4/L5 and L5/S1. The treating doctor then performed left transforaminal epidural steroid injections on 08/28/08, which gave the claimant no more than four days partial relief, followed by full pain return. The TD then performed lumbar discography on 10/21/08 at the L2/L3 and L5/S1 levels. The claimant reported concordant low back pain at each of the two tested levels. Lumbar CT scan following the discogram on 10/21/08 demonstrated no evidence of annular tear or disc herniation and no extravasation of contrast dye outside of the annulus.

On 10/29/08 follow up his continuing low back pain radiating to the buttock was noted. He noted the failure of transforaminal epidural steroid injection to provide significant relief and recommended that the claimant undergo L5/S1 IDET based upon the lumbar discography and CT scan performed on 10/21/08.

Two physician advisers subsequently evaluated this request, both of whom recommended non-authorization of the request. Each of the physician advisers cited ODG Treatment Guidelines and the lack of valid results from lumbar discography in their recommendations.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

As each of the two previous physician advisers have stated, there is no support in ODG Treatment Guidelines for the IDET procedure. In fact, the procedure is considered investigational/experimental, according to ODG Treatment Guidelines.

Even if ODG Treatment Guidelines supported the IDET procedure, this claimant is not currently, nor was he ever, a valid candidate for that procedure. Since both of the discs previously tested produced concordant pain, there is no control level against which to judge the validity of this subjective pain complaint. In light of the CT scan that followed the discogram demonstrating no evidence of annular tear or dye extravasation, this claimant, therefore, had discogram results of concordant pain when there was, in fact, no pathology in either of the discs that were tested. Therefore, the results of the discogram are invalid and exclude the claimant from any consideration for the IDET procedure according to the criteria published for determining candidacy of this procedure.

Therefore, based upon both ODG Treatment Guidelines, as well as the criteria published for determination of candidacy for the IDET procedure, this claimant is not a valid candidate for the IDET procedure. The previous recommendations for non-authorization are, therefore, upheld. There is no justification for performing the IDET procedure on any disc for which there is no objective evidence of pathology, especially with invalid discogram findings such as are present in this case.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)