

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

62290 Diskogram, Lumbar; 72295 X-Ray of Lower Spine Disk

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

MD, 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for 62290 Diskogram, Lumbar; 72295 X-Ray of Lower Spine Disk.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/23/08, 11/05/08
ODG Guidelines and Treatment Guidelines
Office notes, Dr. , 5/22/06, 02/15/07
Psychological screening, Dr. , 03/22/07
Operative report, Dr. , 03/26/07
MRI lumbar spine, 09/10/07
Office notes, Dr. r, 01/30/08, 06/18/08, 09/16/08
Lumbar myelogram, 06/04/08
CT myelogram, 06/04/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old male who was status post March 2005 L5 laminotomy with persistent low back and paresthesias to his lower leg. The post lumbar myelogram and CT, dated 06/04/08, showed at L2-3, a 2 millimeter right posterolateral disc bulge. At L4-5 there was a 2-3 millimeter broad based central disc bulge/protrusion and at L5-S1 a left laminotomy with 2-3 millimeter retrolisthesis. Four millimeter broad based central soft tissue density postoperatively with associated osteophyte was reported.

Additional to 4+ to 5 millimeter left posterolateral (foraminal) osteophyte producing moderate left neural foraminal stenosis, becoming more severe inferiorly was noted. Dr. Guyer saw the claimant on 09/16/08 and recommended a discogram to determine if the L4-5 level was a pain generator.

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

The claimant underwent surgery by Dr. on 03/26/07. Postop MRI showed postop changes with question of recurrent persistent disc. Lumbar myelogram and CT myelogram were performed 06/04/08 showing disc bulging at L2-3, L4-5, and L5-S1, postop changes with a 2 to 3 millimeter retrolisthesis and a soft tissue density postoperatively with associated osteophyte with moderate left neural foraminal stenosis, more severe inferiorly. There was possible compromise of the left side dorsal root ganglion at the level. Dr. recommended a discogram or interbody fusion with indirect decompression. He considered including the L4-5 level. Dr. evaluated the patient back on 09/16/08 and recommended a discogram at L3-4, L4-5, and L5-S1 to determine if L4-5 was involved as there was a bulge on myelogram.

Based on review of the medical records provided and the evidence based medicine and ODG guidelines, 62290 Diskogram, Lumbar; 72295 X-Ray of Lower Spine Disk would not be recommended as medically indicated and necessary at this time. It is unclear if repeat EMG/NCS confirms radicular irritation. It is unclear if the patient had exhausted conservative measures with physical therapy, stretch, strength, range of motion, modalities, anti-inflammatory medications, oral steroid preparations, or pain medications. Based on the above issues and without evidence of progressive neurologic deficit and without recent psychosocial assessment to assess the patient as a reasonable candidate to consider further active treatment with discography or fusion, the reviewer finds that medical necessity does not exist for 62290 Diskogram, Lumbar; 72295 X-Ray of Lower Spine Disk.

Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, low back
Discography is Not Recommended in ODG.

Patient selection criteria for Discography if provider & payor agree to perform anyway:

- 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.

o Briefed on potential risks and benefits from discography and surgery

o Single level testing (with control) (Colorado, 2001)

o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification

Indications for imaging -- Plain X-rays:

- Thoracic spine trauma: severe trauma, pain, no neurological deficit
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma (a serious bodily injury): pain, tenderness
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture
- Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70
- Uncomplicated low back pain, suspicion of cancer, infection
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient

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)