



Notice of Independent Review Decision

DATE OF REVIEW: 7/22/08

Date Amended: 7/24/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for low pressure lumbar discogram with post CT scan.

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

Texas licensed 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 previously denied request for low pressure lumbar discogram with post CT scan.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Submitted Medical Information Cover Letter dated 7/15/08.
- Fax Cover Sheet/Comments/Message dated 7/10/08, 3/26/08, 3/13/08, 1/15/08, 1/2/08, 12/13/07.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/10/08.
- Notice of Assignment of Independent Review Organization dated 7/10/08.
- Notice to CompPartners, Inc. of Case Assignment dated 7/10/08.
- Company Request for Independent Review Organization dated 7/8/08.
- Request Form Request for a Review by an Independent Review Organization dated 7/8/08.
- Peer Review Report dated 6/25/08, 6/11/08.
- Determination Notification Letter dated 6/25/08, 6/11/08, 5/23/08, 2/28/08.
- Procedure Orders dated 6/6/08.
- Health Insurance Claim Form/Notice dated 5/8/08, 4/23/08, 4/16/08, 4/10/08, 2/29/08, 2/20/08, 2/19/08, 2/4/08, 1/23/08, 11/12/07, 10/8/07, 10/3/08, 10/1/07, 9/25/08, 9/24/07, 9/20/07, 9/18/07, 9/12/07, 9/4/07, 8/27/07, 8/20/07, 8/15/07, 8/14/07, 8/13/07, 8/6/07, 7/23/07, 7/18/07, 7/17/07, 7/16/07, 7/9/07.
- Follow-Up Consultation Notes dated 5/8/08, 4/23/08.
- Cervical Spine X-Ray dated 4/16/08.
- Lumbar Spine X-Ray dated 4/16/08.
- Patient Information Summary/Orthopedic Consult Report dated 4/16/08.
- Texas Workers' Compensation Work Status Report dated 4/16/08.
- Initial Consultation Notes dated 4/10/08.
- Findings of Fact Clarification Letter dated 4/9/08.
- Re-Evaluation Report/Letter dated 3/17/08.
- Initial Pre-Authorization Request dated 3/17/08.
- BTE Technologies Evaluation Results Report dated 3/12/08.
- Explanation of Billing dated 3/4/08.
- Lumbar Spine Epidural Steroid Injection Treatment (First Series) under Intravenous Sedation dated 2/29/08.
- Follow-Up Visit Report/Letter dated 2/20/08, 9/24/07, 8/6/07, 1/23/08, 9/12/07, (unspecified date).
- Billing Statement dated 2/20/08.
- Texas Workers' Compensation Work Status Report dated 2/19/08, (unspecified date).
- Functional Capacity Evaluation Report dated 2/19/08.
- Designated Doctor Evaluation Report dated 2/19/08.

- Report of Medical Evaluation dated 2/19/08.
- Statement for Services/Final Invoice dated 2/6/08.
- Consultation Report/Letter dated 2/6/08.
- Scheduled Examination Appointment Notification Letter dated 2/5/08.
- Durable Medical Equipment Pre-Certification Form dated 2/4/08, 7/17/07.
- Request Form for Service dated 2/1/08.
- Chest and Lumbar Spine X-Ray dated 1/19/08.
- Commission Order for Attorney's Fees dated 1/9/08.
- Cover Letter/Invoice dated 1/2/08, 12/31/07.
- Medical Records Review Report/Letter dated 12/31/07.
- Fax Cover/Laboratory Results Review Report/Letter dated 12/11/07.
- E-Mail Message dated 12/7/07.
- Notice of Denial of Compensability/Liability and Refusal to Pay Benefits dated 9/14/07.
- Initial Visit Comprehensive Evaluation Report dated 7/16/07.
- Itemized Listing of Attorney's Fees dated 7/17/07.
- Examination Report/Letter dated 7/9/07.
- Notices/Billing Statement of Medical Payment Dispute dated 6/21/08, 6/11/08, 6/10/08, 5/16/08, 4/2/08, 3/27/08, 3/26/08, 3/25/08, 3/15/08, 3/13/08, 3/3/08, 2/21/08, 2/18/08, 2/14/08, 1/4/08, 12/18/07, 12/10/07, 12/7/07, 11/19/07, 11/9/07, 11/6/07, 11/5/07, 11/1/07, 10/9/07, 10/7/07, 10/4/07, 9/18/07.
- Progress Note dated 11/12/07, 10/23/07, 10/8/07, 10/3/07, 10/1/07, 9/25/07, 9/20/07, 9/18/07, 9/12/07, 9/4/07, 8/27/07, 8/20/07, 8/15/07, 8/14/07, 8/13/07, 8/6/07.
- SOAP Note dated 8/13/07.
- Drug Screening Laboratory Results dated 7/30/07.
- Payment Request Letter dated 7/27/07.
- Examination Report/Letter dated 7/23/07, 7/9/07.
- Cervical Spine MRI dated 7/18/07.
- Cervical/Lumbar Spine X-Ray dated 7/18/07.
- Lumbar Spine MRI dated 7/18/07.
- Initial Visit Comprehensive Evaluation Report dated 7/16/07.
- Texas Workers' Compensation Commission Statement of Pharmacy Services dated 7/16/07.
- Pre-Certification Request Form (unspecified date).
- Request for Designated Doctor (unspecified date).
- Income Benefit Summary (unspecified date).
- Assessment Note (unspecified date).
- Article/Literature (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Forklift injury

Diagnosis: Herniation at L5-S1 with S1 radiculopathy and C3-4 disk herniation.

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

The claimant is a xx-year-old male with the date of injury of xx/xx/xx. The mechanism of injury was using a forklift, when the forklift tanks were in the truck that pulled away and allowing the tanks to go to the floor very rapidly, tipping the forklift over, and causing an injury to his neck and low back. The diagnosis was herniated nucleus pulposus at L5-S1 with S1 radiculopathy, C3-C4 disk herniation.

The claimant had received conservative treatment including chiropractic care, physical therapy, medications, and epidural steroid injections. As of February 6, 2008, in an evaluation by , D.O., the claimant was complaining of an aching type of pain of in the cervical spine, and an aching type of pain in the low back with pins and needles and with radiation to both thighs. After Dr. 's evaluation, he noted the claimant was a candidate for epidural steroid injections.

Also a Maximum Medical Improvement (MMI) determination report by Dr. on March 7, 2008, noted the claimant was not at maximum medical improvement. The claimant then underwent epidural steroid injections with Dr. on April 16, 2008. The claimant indicated the back pain was greater than the leg pain. Physical examination noted pain with right straight leg raising but no indication regarding positive or negative for back or leg pain. Deep tendon reflexes were 2+ and symmetrical, motor was 5/5, and sensory was intact. At that time, diskography was recommended with a CT from L3-L4 to L5-S1.

The rationale for non-certification of the lumbar diskography is the ODG, web based, 13th Edition, indicate diskography is not recommended and notes the conclusion of recent high quality studies on diskography have significantly questioned the use of diskography results as a preoperative indication for either intradiscal electrothermal therapy (IDET) or spinal fusion. Campbell's Operative Orthopedics notes the clinical use for most of the data obtained from diskography still remains controversial. Without discography, the CT scan is questionable for this one year old injury.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
Low back – discography and CT imaging.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).