

## **I-Resolutions Inc.**

*An Independent Review Organization*

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### Notice of Independent Review Decision

**DATE OF REVIEW: JULY 31, 2008**

**IRO CASE #:**

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

72131, CAT scan of lower spine and 72295, LUMBAR DISCOGRAM

**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 72131, CAT scan of lower spine and 72295, LUMBAR DISCOGRAM.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 6/20/08, 7/10/08  
ODG Guidelines and Treatment Guidelines  
Dr. MD, 6/10/08  
Lumbar MRI, 2/18/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is an injured worker who works for xx. He apparently had a palate fall onto his shoulder while at work. This caused him to brace his left leg suddenly. He developed

onset of back pain and did not have a previous history of back pain. Apparently his back pain has been consistent with some left-sided leg pain additionally. His back pain is greater than his leg pain. He has taken Tramadol and Skelaxin. He has had two epidural steroid injections without help and physical therapy at Healthcare facility without any help. An MRI scan revealed a herniated disc at L4/L5, 3-mm, and 5-mm at L5/S1 with some disc space narrowing and degeneration seen at L4/L5. There was some mild retrolisthesis at L4/L5, but there was no motion with flexion and extension. He was seen by Dr. for a second opinion, and a discogram has been recommended. The records provided indicate that the discogram is being ordered to determine whether or not this patient is a surgical candidate rather than to determine the extent of surgery required. The medical records which were provided do not indicate that this patient is being scheduled for surgery for this particular problem.

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

Based upon the North American Spine Society Protocol for Provocative Discography, discograms should be utilized to determine the extent of pathology and whether a particular lesion should be included in the fusion once the decision for surgery has already been made. ODG Guidelines are even more restrictive in that instability is the predominant criteria for fusion, and discography, while utilized extensively, is not a procedure that is endorsed except under unusual circumstances by ODG Guidelines. Furthermore, in this particular case a psychological assessment has not been performed, and ODG Guidelines utilize the term "carefully selected patients" when discussing fusion. It is for the combination of the above reasons that the previous adverse determination has been upheld. The reviewer finds that medical necessity does not exist for 72131, CAT scan of lower spine and 72295, LUMBAR DISCOGRAM.

**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:** North American Spine Society's Protocol of Provocative Discography