

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: MAY 26, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ODG Discogram/CT lumbar L3-4, L5-S1

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

M.D., 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 ODG Discogram/CT lumbar L3-4, L5-S1 is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters
ODG Guidelines and Treatment Guidelines
MD, 2/19/08, 4/8/08, 4/23/08
DO, 10/29/07
MRI of Lumbar Spine, 10/18/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was initially injured at work when she fell, twisting her left foot in a wire. She has had multiple conservative therapies including six cortisone injections along with an

epidural injection, which gave her some brief pain relief. She has had hydrocodone, Flexeril, and lisinopril. She has completed physical therapy. She has also undergone individual psychotherapy. She has been noted to be motivated and compliant. The psychological evaluation reports that there are no psychological obstacles for her undergoing discogram or lumbar fusion surgery. A decision has already been made that she is a candidate for lumbar fusion surgery due to the retrolisthesis at L4/L5. There is also another abnormal motion segment at L3/L4, and the records state that the lumbar discogram has been ordered in order to determine whether or not the L3/L4 discs should be excluded from the surgical fusion recommended.

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

This patient has already been determined to be a lumbar fusion candidate by her surgeon. He is interested in determining whether or not she can be handled with a one-level fusion or requires a two-level fusion. This is the precise criteria outlined in the ODG Treatment Guidelines. The North American Spine Society Physician Statement of Provocative Discography recommends the use of discography in the patient with abnormalities on the MRI scan in order to determine the extent of fusion but not the indication of fusion. ODG Guidelines reflects this thought process, and in this stable patient, which has been determined by her behavioral health evaluations to be the case in this patient, in the patient who has already been a candidate for fusion, the discogram can be used to exclude additional motion segments that appear possibly symptomatic on the MRI studies. It is for this reason that the patient falls into the category of patients that the ODG Guidelines consider acceptable candidates for discography. For this reason, the medical necessity as requested by the treating physician is upheld, and the previous adverse determination is overturned. The reviewer finds that ODG Discogram/CT lumbar L3-4, L5-S1 is medically necessary.

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 Physician Statement of Provocative Discography)**