

Clear Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW: NOVEMBER 14, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar CT scan, diskography L3-S1.

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 outpatient lumbar CT scan, diskography L3-S1.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 9/8/08, 10/8/08

ODG Guidelines and Treatment Guidelines

Office notes, Dr., 07/15/08

Office notes, 09/02/08

Request for CT discogram, 09/08/08

Management, 09/08/08

Office note, Dr. , 09/19/08

Pre-authorization request, 10/01/08, 10/16/08

Peer review, 10/07/08

Dr., 10/14/08, 10/21/08
Radiology Order Form, undated
Referral Order, 09/03/08
Records, 10/08/08, 10/21/08, 10/28/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male injured on xx/xx/xx when he was bending forward apprehending a suspect. He was seen by Dr. on 07/15/08 for lumbar pain radiating to the mid thoracic region. Dr. noted that the claimant had two previous MRI scans that showed annular tearing at L5-S1. Cervical and thoracic MRI studies were recommended. On 09/02/08 the PA-C indicated that the cervical MRI showed degenerative change at C4-5 and 5-6, the thoracic scan was negative and the lumbar MRI showed degenerative changes at L4-5 and L5-S1. A CT discogram was ordered on 09/08/08 for potential surgery. The request was denied. Dr., PhD, evaluated the claimant on 09/19/08 and felt there was no contraindication to testing or surgery. The CT discogram was once again requested and denied. Dr. authored letters of appeal for the testing noting that the claimant had been treated with therapy, Tramadol, Flexeril and epidural steroid injection without benefit. As Dr. felt the claimant was a candidate for fusion, the CT discogram was an appropriate test to determine if both L4-5 and L5-S1 needed to be included.

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

Review of the records provided supports the claimant is a gentleman who reports low back pain after a bending injury xx/xx/xx. The cervical spine MRI showed degenerative discs of the neck. Lumbar spine MRI showed degenerative discs at L4-5, L5-S1. They recommended CT/discogram if he wishes to consider surgery. Based solely on review of the records provided, it is unclear if the claimant has failed conservative measures, physical therapy, stretch, strength, range of motion modalities, anti-inflammatory medications, oral steroid preparations, or epidural steroid injections as a diagnostic and potentially therapeutic modality. It is unclear if the claimant has undergone a psychosocial assessment to see if he would be a good candidate for spinal surgery. There is no evidence of motion segment instability or progressive neurologic deficit. The actual MRI report is not available for review itself. Given the above issues, the reviewer cannot recommend CT/discography for this claimant. The reviewer finds that medical necessity does not exist for outpatient lumbar CT scan, diskography L3-S1.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates,

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

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)