

## **I-Resolutions Inc.**

*An Independent Review Organization*

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### Notice of Independent Review Decision

**DATE OF REVIEW: OCTOBER 8, 2008**

**IRO CASE #:**

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

Lumbar Discogram w/ Post CT Scan

**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.

Based upon the review of the medical records and psychological assessment, this reviewer is of the opinion that the criteria for the use of discography in this patient has been met. The reviewer finds that medical necessity exists for Lumbar Discogram w/ Post CT Scan.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 9/9/08, 8/22/08

ODG Guidelines and Treatment Guidelines

Diagnostic , 9/15/08, 8/28/08

, DC, 7/8/08, 4/7/08

, 7/29/08

PPE, 5/25/08

, MD, 4/21/08

MRI of Lumbar Spine, 4/8/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is an injured worker who, according to history, was injured at work and sustained axial back pain with some complaints of intermittent radicular type of complaints. He had an MRI scan, which revealed on 04/08/08 an annular tear at L4/L5 and a protrusion at L5/S1, but other adjacent levels based on the MRI scan were normal. He previously worked as a truck driver and was injured in that employment. He had chiropractic and physical therapy. He also has had a psychological assessment, which revealed he does not have psychological barriers to discography or to lumbar fusion. He has been said to be a candidate for surgery based upon the one-level or possibly two-level abnormal findings on the MRI scan.

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

Based upon the ODG Guidelines, discography would be appropriate for a patient who is "well selected," i.e., would meet the criteria for one-level or two-level surgery, and has abnormal findings on the neural imaging study. This gentleman does have abnormal findings at one or two levels and has already been determined to be a potential surgical candidate. According to the medical records, the prospective discography would be used to determine the extent of surgery and not the criterion for surgery. The guidelines also require that there is the possibility of control levels, which is the case in this particular instance. It is with all of this in mind that the ODG criteria for consideration of discography are met. The psychological screening has revealed that this is a patient who would fall into the "well selected patient" category. It is for these reasons that the previous adverse determination is overturned. Based upon the review of the medical records and psychological assessment, this reviewer is of the opinion that the criteria for the use of discography in this patient has been met. The reviewer finds that medical necessity exists for Lumbar Discogram w/ Post CT Scan.

**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 on Provocative Discography**