



# Lumetra

Brighter insights. Better healthcare.

One Sansome Street, Suite 600  
San Francisco, CA 94104-4448

415.677.2000 Phone  
415.677.2195 Fax  
www.lumetra.com

## Notice of Independent Review Decision

**DATE OF REVIEW:** 4/20/09

**IRO CASE #:**

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

Lumbar discogram with CT scan L2-3 and L5-S1

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

Certified by the American Board of Orthopaedic Surgery and fellowship trained in spine surgery

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
05/09/2008	210W08103013	Prospective	724.02	72295	Overturned
05/09/2008	210W08103013	Prospective	722.52		Overturned
05/09/2008	210W08103013	Prospective	738.4		Overturned

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Behavioral Medicine Evaluation dated 3/13/09

Physician notes dated 2/24/09, 2/3/09

X-ray report dated 2/24/09

Procedure note dated 1/14/09  
MRI report dated 6/4/08

Official Disability Guidelines cited - Discography

**PATIENT CLINICAL HISTORY:**

According to the information provided, this claimant sustained a lower back injury on xx-xx-xx while lifting a cement block. Prior treatment has included caudal/lumbar epidural steroid injection, physical therapy, and medications. An MRI scan and plain x-rays were obtained. An evaluation on 2/24/09 noted that the claimant continues to complain of back pain. On 3/13/09 the claimant underwent a behavioral medicine evaluation and was cleared for the discogram procedure. The next step in the treatment plan includes a discogram: if the claimant has positive concordant back pain, surgical treatment options including fusion versus fusion and a hybrid arthroplasty at the superior level, would be considered.

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

In the Reviewer's opinion, the requested discogram procedure should be authorized as requested. The Reviewer noted that this patient has bilateral spondylolysis of the lumbar L5 spine and may require surgical treatment. According to the Reviewer, the claimant has evidence of instability, noted on the MRI scan as anterolisthesis as well as clinical radiculopathy, with combination instability/facet arthrosis syndrome. The Reviewer further noted that the claimant completed but failed all appropriate conservative treatment, including an epidural steroid injection. The Reviewer concurred with the treating physician's evaluation plan for a discogram as surgical options are being considered.

In the professional opinion of the Reviewer, this claimant's clinical course and history (i.e., failure of appropriate conservative management and a year of persistent pain since the original injury) qualifies this claimant for the requested discogram procedure according to Official Disability Guidelines and ACOEM guidelines.

References:

RL, et al. Textbook of Operative Spine Surgery. January 2009.

et al. Adult and Pediatric Spine. 3rd edition. 2003.

The Spine. 2nd edition. 2003.

**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)**