

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/10/2009

**IRO CASE #:**

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

X-Ray of Lower Spine (72295); CT of Lumbar spine w/o dye (72131); Discogram

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

M.D., board certified in Orthopedic Surgery

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who has axial back pain and was injured on xx/xx/xx. The patient had injections, which apparently were unhelpful, and various medications for pain. He has had no obvious neurological findings. There was no evidence within the medical records of instability on flexion/extension x-rays. There were degenerative changes seen at L3/L4, L4/L5, and L5/S1 on a CT scan. An MRI scan of the lumbar spine revealed some multilevel disc disease in the lower lumbar spine also with some recessed stenosis. There was also some protrusion seen at L3/L4 and L5/S1. The notes within the medical record indicate that this discogram is being performed to determine if this patient is a surgical candidate.

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

Given the fact that there is no evidence of instability in this patient with documented degenerative disc disease at L3/L4, L4/L5, and L5/S1, this patient would not conform to ODG Guidelines for surgery, even if the discogram was positive. The guidelines allow for the use of provocative discography -- but not to determine if the patient is a surgical candidate but rather to determine the extent of the required fusion surgery. Given the fact that the patient does not conform based upon other imaging studies or the medical records to the ODG Guidelines and Treatment Guidelines, the use of discography at this juncture to determine levels is inappropriate as it would not affect the final decision as to whether or not fusion surgery was required. The other imaging studies requested do not meet the guidelines. The reviewer finds that medical necessity does not exist for X-Ray of Lower Spine (72295); CT of Lumbar spine w/o dye (72131); Discogram.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)