

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Dec/05/2009

**IRO CASE #:**

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

L3-L4, L4-L5, L5-S1 Discogram/CT Scan 72295, 72131, 72100

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

M.D., Board Certified Orthopedic Surgeon  
Board Certified Spine 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines and Treatment Guidelines  
Adverse Determination Letters, 10/29/09, 11/10/09  
Law Firm Letter, 11/19/09  
Request for Discogram, 11/11/09, 11/2/09  
MRI Lumbar Spine, 3/3/09  
MRI Pelvis, 3/3/09  
Neurological Surgery Consultation, 3/23/09  
Lumbar ESI #1, 4/16/09  
Lumbar ESI #2, 5/15/09  
Neurosurgical Follow-up Evaluation, 6/3/09, 9/30/09  
Lumbar ESI #3, 7/29/09  
Pre-procedure Psychological Evaluation, 10/8/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who was injured while lifting. He has a history of having undergone an MRI scan showing a bulging disc at L4/L5 and L5/S1 with an annular tear at L5/S1. He has had psychologic evaluation, which clears him for discography and most likely for surgery also. He has had epidural steroid injections, which gave him temporary relief. He has some back pain with radiating back pain. Diagnosis is discogenic pain syndrome. Request is for provocative discography.

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

Because this patient does not meet the criteria for fusion under the ODG Guidelines, there is no purpose to be served in determining whether or not the annular tear at L5/S1 is a pain generator, and thus, no medical necessity for the requested discogram with post discographic CT scan. The patient would have to demonstrate some instability in order to meet the criteria for fusion. The MRI scan only shows bulging discs. There is no evidence of instability within the medical records provided. Therefore, this request does not conform to the ODG. In addition, no reason has been given by the provider for why the guidelines should not be followed in this particular patient's case. The reviewer finds that medical necessity does not exist for L3-L4, L4-L5, L5-S1 Discogram/CT Scan 72295, 72131, 72100.

**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)