

Notice of Independent Review Decision

DATE OF REVIEW: 3/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

72131: Computed tomography, lumbar spine; without contrast material
72295: Discography, lumbar, radiological supervision and interpretation

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from and completed training in Orthopaedics at . A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Orthopaedics since July 2000 and currently resides in .

REVIEW OUTCOME:

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

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

72131: Computed tomography, lumbar spine; without contrast material	Upheld
72295: Discography, lumbar, radiological supervision and interpretation	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. IRO request form dated unknown.
2. Request for review dated 02/25/2009
3. Clinical note by MD dated 01/26/2009
4. Clinical note by MD dated 02/10/2009
5. Review of case assignment dated 02/26/2009
6. Notice of assignment dated 02/26/2009
7. Request for review dated 02/25/2009
8. Medical dispute resolution by DC dated 02/19/2009
9. Clinical note dated unknown.
10. Clinical note by MD dated 02/10/2009
11. Fax page dated 01/29/2009
12. Pre auth request for lumbar discogram dated 01/26/2009
13. Notification of adverse determination by MD dated 01/26/2009
14. Fax page dated 01/22/2009
15. Final report by MD dated 09/24/2008
16. MRI of the lumbar spine dated 09/26/2007
17. Electro diagnostic results by DO dated 10/02/2008
18. Clinical note by MD dated 11/17/2008
19. Pre procedure psychological evaluation by PsyD dated 12/31/2008
20. Discography dated unknown.
21. Fax page dated 01/29/2009
22. Pre auth request for lumbar discogram dated 01/26/2009
23. Clinical note dated unknown.
24. Notification of adverse determination by MD dated 01/26/2009
25. Discography dated unknown.
26. Final report dated 09/24/2008

27. MRI of the lumbar spine by MD dated 09/26/2007
28. Electro diagnostic results by DO dated 10/02/2008
29. Clinical note by MD dated 11/17/2008
30. Psychological evaluation by PsyD dated 12/31/2008
31. Request for a review dated 02/25/2009
32. Request for a lumbar discogram by DC dated 02/19/2009
33. Clinical note dated unknown.
34. Notification of reconsideration determination by MD dated 02/10/2009
35. Fax page dated 01/29/2009
36. Pre auth request for lumbar discogram dated 01/26/2009
37. Notification of adverse determination by MD dated 01/26/2009
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53. Final report dated 09/24/2008
54. MRI of the lumbar spine by MD dated 09/26/2007
55. Electro diagnostic results by DO dated 10/02/2008
56. Clinical note by MD dated 11/17/2008
57. Psychological evaluation by PsyD dated 12/31/2008
58. Discography dated unknown.
59. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who presented with low back pain. Pain began on xx/xx/xx following a work related accident. He is noted to have failed conservative therapy and is status post L4-S1 fusion on 4/8/2008. The injured employee is noted to have exacerbated his symptoms following a fall on xx/xx/xx. He underwent lumbar discogram with CT scan.

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

The injured worker is a male whose date of birth is listed as xx/xx/xx. He reportedly sustained an injury on xx/xx/xx. Based on the notes it appears the worker was moving a drill collar lift when he developed low back pain. He initially underwent MRI evaluation of the lumbar spine on 09/26/07. The MRI imaging studies are noted to be grossly unremarkable other than mild facet hypertrophy at L4-5, L5-S1. There was no evidence of neural structure impingement, gross degenerative changes, or evidence of fractures etc. The injured employee underwent electrodiagnostic studies which were also noted to be unremarkable. He is reported as having undergone L4-S1 fusion on 04/08/08. Postoperatively on xx/xx/xx, he reported a slip and fall while working. The worker underwent CT scan of the lumbar spine on 09/24/08, which noted "satisfactory post op appearance, no evidence of hardware failure, no evidence of significant stenosis, and satisfactory alignment of bony structures." The documentation indicates the worker is being recommended for CT discography to evaluate L3-4 for continued back pain.

Dr. opines that the injured worker has continued low back pain despite having L4-S1 fusion, and may possibly have pseudoarthrosis despite radiographic evidence to the contrary as the CT scan reported no evidence of nonunion/pseudoarthrosis or hardware failure. It should also be noted this injured worker had a relatively normal MRI and unremarkable electrodiagnostic studies prior to fusion surgery. Fusion surgery very often results in continued back pain. The CT scan showed no evidence of degeneration at L3-4 nor did the preoperative MRI. Despite having a psychological clearance, the patient has no evidence of disease process on imaging studies at L3-4, and again has only residual low back pain following 2-level lumbar fusion. There is no basis for discography with post CT scan at this time. Therefore, the previous denial is upheld. This is in accordance with the ODG guidelines.

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

X 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)