



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

DATE OF REVIEW: 11/19/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar discogram post CT scan

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

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

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
721.3	62290		Prosp.	1	10/06/99 – 11/06/09				Overturn
721.3	72295		Prosp.	1	10/06/09 – 11/06/09				Overturn
721.3	77003		Prosp.	1	10/06/09 – 11/06/09				Overturn
721.3	72132		Prosp.	1	10/06/09 – 11/06/09				Overturn

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient has complained of persistent low back pain after a work-related injury. He was previously treated with lumbar epidural steroid injections. However, he continues to have pain. MRI scan shows multiple levels of disc pathology, i.e. three levels. He has failed conservative management and is now in consideration of surgical management. EMG documents L5 radiculopathy. Preoperative behavioral health assessment indicates that continued medical management would be appropriate for this patient.

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

The patient has failed conservative management and has an L5/S1 lumbar radiculopathy. However, he has a fair amount of axial low back pain and disc abnormalities at the two levels above this. The patient has been cleared for surgical management. In light of the upcoming surgical management, surgical planning is sometimes assisted by lumbar discography. There is no psychological factor that would preclude this examination and would assist the requesting surgeon in surgical planning.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:


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(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)