

SENT VIA EMAIL OR FAX ON
Apr/05/2010

Pure Resolutions Inc.

An Independent Review Organization
1124 N Fielder Rd, #179
Arlington, TX 76012
Phone: (817) 349-6420
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Spine CT / Discogram at L3/4, L5/S1 as an outpatient

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Denial Letters 2/11/10 and 2/24/10

Ortho 1/10/03 thru 3/17/10

OP Report 6/3/03, 1/29/03, 3/6/03, 5/14/03, and 1/19/10

MRIs 4/29/03 & 5/1/03, 12/31/02, 2/20/03, 12/21/09

X-Ray 3/6/03

Peer Review 2/24/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a date of injury xx/xx/xx, when he was repairing a laser system. He is status post L4-L5 discectomy 03/06/2003. On 06/03/2003 he underwent surgery for a recurrent disc herniation. He did well until 01/2009, when he started to develop low back and left leg pain. His neurological examination is significant for decreased sensation to the left lateral calf and dorsum of the left foot. An MRI of the lumbar spine with and without contrast

12/21/2009 reveals minimal epidural fibrosis with no evidence of recurrent disc at L4-L5. There is no central canal compromise or significant foraminal narrowing at any level. At L5-S1 there is a minimal posterior broad-based disc bulge with right lateral recess narrowing at L5-S1. On 01/19/2010 he underwent bilateral L4-L5 and L5-S1 facet injections. He had significant improvement in the pain that lasted for three days. The provider is considering a total disc arthroplasty at L4-L5, but would like to obtain a lumbar discogram to assess the L3-L4 and L5-S1 levels.

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

The lumbar discogram is not medically necessary. According to the Official Disability Guidelines, "Low Back" chapter, discography is typically not recommended, but if performed, a detailed psychological evaluation should be done prior to discography. There is not evidence that this has been done. Also, according to the same guidelines, there should be "failure of recommended conservative treatment including active physical therapy". It is not clear that the claimant has failed a recent course of conservative therapy. For these reasons, the lumbar discogram is not medically necessary.

References/Guidelines

2010 *Official Disability Guidelines*, 15h edition

While not recommended above, if a decision is made to use discography anyway, the following criteria should apply:

- o Back pain of at least 3 months duration
- o Failure of recommended conservative treatment including active physical therapy
- o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)
- o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided)
- o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) ([Carragee, 2006](#)) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria.
- o Briefed on potential risks and benefits from discography and surgery
- o Single level testing (with control) ([Colorado, 2001](#))
- o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification)

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)