

MEDRx

791 Highway 77 North, Suite 501C-316 Waxahachie, TX 75165
Ph 972-825-7231 Fax 972-775-8114

Notice of Independent Review Decision

DATE OF REVIEW: 12/7/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of discography, lumbar, radiological supervision and interpretation.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of discography, lumbar, radiological supervision and interpretation.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: and Dr. .

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from: 11/18/10 letter by, 10/5/10 denial letter, 11/4/10 denial letter, 10/5/10 report by MD, 11/3/10 report by MD, 9/30/10 procedure order, 7/15/10 to 9/24/10 office notes by Dr., 9/15/10 BHI 2 report, lumbar myelogram and CT report 7/27/10, 7/26/10 lumbar series

report, 8/16/10 CMT and ROM report, undated lumbar x-ray report, 4/1/10 lumbar MRI report, 12/16/09 lumbar post myelogram CT report, 1/12/10 discharge, operative and Hx and Physical notes by MD, analysis of ODG position on discography, 'systematic review of lumbar provocation discography...study by Wolfer et al, systematic review of discography as a diagnostic test...study by Buenaventura et al, study by Lettice, et al Does the number of levels affect lumbar fusion outcome?', study by Moore et al; DDD treated with combined anterior and posterior arthrodesis..., study by Tomcek; discography interpretation..., study by Derby et al; the ability of pressure controlled discography to predict surgical and nonsurgical outcomes and a study by Shin et al; diagnostic relevance of pressure controlled discography. Dr.: 7/12/10 letter by, follow up notes by Dr. 7/23/09 to 7/1/10, xpress care follow up notes 5/15/09 to 12/23/09, 11/8/10 MMT and ROM report, 10/5/10 Tel Conference report, 9/24/10 CMT and ROM report, 8/23/10 precert request, 8/25/10 approval letter, 7/15/10 CMT and ROM report, 4/8/10 laboratory report, 1/13/10 laboratory report, 1/11/10 laboratory report, 1/12/10 pathology report, 1/12/10 lumbar x-ray report, 1/11/10 PA chest x-ray report, 1/11/10 EKG report, 12/16/09 laboratory report, 12/15/09 laboratory report, 12/15/09 EKG report, 12/15/09 lumbar x-ray series report, 12/15/09 chest x-ray report, 9/8/09 to 11/2/09 outpatient clinical assessment report, 9/8/09 to 11/2/09 lumbar assessment addendum, 9/25/09 FCE summary, 9/25/09 FCE report, 8/19/09 neurodiagnostic report and 7/11/09 lumbar MRI report.

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who was injured on xx/xx/xx while attaching a 175 lb rope to a crane shackle and felt a pain in his back radiating to his right leg. The patient underwent lumbar laminectomy L4-5 performed on 1/12/2010, without improvement of his back pain. Exam noted weak right compared to left leg, decreased sensation anterior and lateral right leg, reflexes that are 2+ and equal bilaterally. A CT myelogram noted right L4 laminectomy defect and no significant abnormality.

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

Discograms are not recommended under ODG Guidelines without agreement between the carrier and treating physician under the following criteria:

- 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) 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)
- o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification

All of the above factors are not met as the BHI2 does not qualify in the reviewer's opinion as a detailed psychosocial assessment. Therefore, the requested procedure is not medically necessary at this time.

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 KNOWLEDGBASE
- 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)**