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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/28/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Low Pressure Lumbar Discogram with Post Ct Scan With Contrast

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

MD, Board Certified Orthopedic 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

Adverse Determination Letters, 11/10/09, 11/24/09

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Low Back

Email notes from carrier, 6/18/07-11/24/09

Medicine and Rehabilitation 6/15/07, 9/5/07, 8/31/07, 8/29/07, 8/27/07, 8/24/07

MRI Cervical Spine without contrast, 6/4/07

MRI Lumbar Spine without contrast, 6/4/07

Employers First Report of Injury or Illness, xxxx

Specialty Clinic, 1/23/08

MD, 2/26/08, 4/1/08, 4/24/08, 5/22/08, 3/20/08, 8/14/08, 7/17/08, 6/10/08

Pain Center, 4/1/08

Operative Report, 5/8/08, 4/10/08

DC, 9/25/08, 10/1/08

MD, 10/29/09, 10/28/09, 9/22/09

Therapy and Diagnostics, 10/29/09

Xray, Lumbar, 9/22/09

MRI Lumbar Spine, 9/11/08

MD, 3/4/09

BHI 2, Interpretive Report, 10/28/09

Instructional Course Lectures, Spine OKU Spine 3

PATIENT CLINICAL HISTORY SUMMARY

An evaluation completed by D.C. noted that the injured employee was working overhead and sustained neck and low back injuries in xxxx. Records are provided showing extensive chiropractic care. An MRI of the cervical spine noted uncovertebral hypertrophy at multiple levels. There was no disc herniation or protrusion identified. In the lumbar region of the spine there was degenerative disc disease with desiccation at the lower two levels. A disc herniation was noted at the L5/S1 level. Multiple chiropractic interventions are noted. Dr. noted lumbar discogenic pain and lumbar radiculopathy. Dr. completed an evaluation on February 26, 2008. Dr. felt that there was a need for a repeat MRI study. Multiple level degenerative changes were identified, as was the disc lesion. Epidural steroid injections were also suggested. Ultimately, the injured worker underwent lumbar spine surgery. However, this did not ameliorate the pain complaints. Subsequent to this procedure, the claimant was evaluated by Dr. This evaluation precipitated a request for a lumbar discogram. Dr. notes that the diskogram (in conjunction with the MRI) will be used to exclude either L4-5 or L5-S1 from proposed surgery. Repeat MRI noted the degenerative changes, partial discectomy, partial hemilaminotomy and no acute dissolution. A peer reviewer indicated that no further surgical interventions were warranted. In November 2009, the request for discogram was non-certified. A reconsideration was filed and also non-certified.

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

The ODG states that discography is of limited value, and therefore does not recommend the procedure, stating that “the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion.” The reviewer finds that medical necessity does not exist for Low Pressure Lumbar Discogram with Post Ct Scan With Contrast.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Low Back.

Lumbar Discography

Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) is of limited diagnostic value.

Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion (but a positive discogram in itself would not allow fusion)

Discography is Not Recommended in ODG

Patient selection criteria for Discography if provider & payor agree to perform anyway

- 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)