

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 1/11/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Injection procedure for Discography, each level, cervical or thoracic

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. 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 Physical Med & Rehab since 7/1/2006 and Pain Management since 9/9/2006. This reviewer currently resides in TX.

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) |

Injection procedure for Discography, each level, cervical or thoracic Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Reviews of case assignment by dated 12/22/2009
2. Fax page dated 12/21/2009
3. IRO request form by author unknown dated 12/21/2009
4. Fax page dated 12/18/2009
5. Request form by author unknown dated 12/18/2009
6. Letter by dated 12/10/2009
7. Letter by dated 11/09/2009
8. Clinical note dated unknown
9. Fax page by author unknown dated 12/24/2009
10. Final report by dated 10/21/2009
11. Clinical note by MD dated 10/19/2009 & 10/28/2009
12. Prescription note by author unknown dated 10/19/2009
13. Procedure orders by author unknown dated 9/28/2009 & 10/28/2009
14. Motor nerve study by MD dated 6/26/2009
15. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This injured employee is a male injured in a motor vehicle crash (MVC) on xx/xx/xx. He complains of neck and arm pain. He has been treated with physical therapy (PT), trigger point injections, manipulation and medications. MRI cervical spine on 10/21/09 shows C5/6 disk protrusion with desiccation, other discs within normal limits. A note on 10/28/09 by Dr. xxxxxx notes complaints of continued neck and back pain. Exam is not remarkable. Plan is for CT/discogram. Office note on 10/19/09 notes EMG which shows carpal tunnel syndrome and right C6 radiculopathy. Exam notes limited cervical range of motion, equal reflexes, and decreased strength throughout the right side compared to the left. Diagnoses are double crush syndrome at C6 and carpal tunnel. Recommendation then is for carpal tunnel release followed by anterior cervical fusion discectomy if carpal tunnel release is unsuccessful.

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

ODG does not recommend use of discography for suspected discogenic pain syndrome. As noted in the guidelines, if the injured employee/provider do agree to perform the diagnostic procedure it is recommended the following criteria be met: 1) Neck pain of 3 or more months, 2) Failure of recommended conservative treatment, 3) 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), 4) Satisfactory results from psychosocial assessment (discography in subjects with emotional and chronic pain has been associated with reports of significant prolonged back pain after injection, and thus should be avoided), 5) Should be considered a candidate for surgery, 6) Should be briefed on potential risks and benefits both from discography and from surgery, 7) Due to high rates of positive discogram after surgery for disc herniation, this should be potential reason for non-certification. According to the submitted medical documentation, there is no evidence the injured employee has undergone any psychosocial pre-screening assessment or been briefed on potential risks and benefits both from discography and from surgery. Based on these factors the requested cervical discogram/CT is not considered medically necessary. Recommendation is to uphold prior denials.

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)