

SENT VIA EMAIL OR FAX ON  
May/15/2010

## Independent Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/11/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Injection for Spine Disk X-Ray; CT Lumbar Spine w/o Dye; X-ray of lower spine disk

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC SURGERY

**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 2/19/10 and 3/11/10  
Dr. 6/1/09 thru 4/7/10  
MRI 4/10/09  
Spine 3/30/09  
Clinic 3/30/09 thru 5/20/09  
Dr. 5/14/09 thru 2/25/10  
Progress Notes 5/13/09 thru 5/20/09  
OP Report 7/23/09  
DDE 3/24/10

#### **PATIENT CLINICAL HISTORY SUMMARY**

This is a woman injured on x/xx/xx. She has back pain and reported right S1 distribution of symptoms. She had an EMG in 1/10 that showed a bilateral sensory neuropathy and bilateral absent H reflexes. There were no needle abnormalities. The MRI showed a right-sided protrusion at the L5/S1 neural foramen. She had some relief with a right transforaminal ESI. Dr. Potter requested that the neurosurgeon wishes the discogram prior to surgery "to try to make sure as we have as good a chance as possible...that she has good results..." He stated Surgery would continue without the discogram if approved.

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

This test has remained controversial. The ODG does not recommend it. It can be considered if there is a reason for internal control, if there is a psychosocial assessment, and if a fusion is contemplated, but would not be performed with the discogram findings. The only notes that the IRO reviewer saw from Dr. the neurosurgeon, are from May 2009 and 2/25/10. There is no treatment plan noted, just a page of complaints, ROS and vital signs. In the absence of more information, nothing was provided to justify a discogram per the ODG criteria.

Further, the American Pain Society guides published in Spine, Volume 34, 2009 page 1074 state

"Provocative discography is not recommended because its diagnostic accuracy remains uncertain, false-positives can occur in persons without low back pain, and its use has not been shown to improve clinical outcomes. "

#### **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)