

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** SEPTEMBER 22, 2010

**IRO CASE #:**

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

Medical necessity of proposed IDET, single level (22526)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

### **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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.52	22526		Prosp	1					Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-15 pages

Respondent records- a total of 50 pages of records received to include but not limited to: TDi letter 9.2.10; M.D. report 8.10.10; Pain Consultants records 8.2.10-8.20.10; M.D. report 8.27.10; letter 8.27.10; letter 5.13.08, 10.10.05

Requestor records- a total of 24 pages of records received to include but not limited to: PHMO Notice of an IRO; Pain Consultants records 1.15.10-8.16.10

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The medical records presented for review begin with a January 10, 2010 evaluation. It is noted that this patient had originally been injured in xx/xxxx. There was no care reported between 2002 through 2005, in 2005 it is noted that there was an MRI of the low back and that there had been chronic pain issues from 2005 through 2010. Electrodiagnostic assessment completed in April 2009 was negative for a verifiable radiculopathy.

The physical examination and noted a 5'6" 191 pound female in no acute distress. There was a full range of motion to flexion and some painful motion with extension, without evidence of a radiculopathy. It was noted that a transforaminal epidural steroid injection would be requested at the L4/5 level. The request for an epidural steroid injection was not certified. There continued to be latent left leg pain in an L3, L4 and L5 pattern.

It would appear that the non-certification of the epidural steroid injection was overturned and on February 15, 2010 the injection was completed. It was reported that there was zero pain after the

injection. It is reported that there was complete pain relief for approximately one week and moderate pain relief for an additional three days.

There was some pathology to the annulus and it was felt that there was a radiculitis secondary to the chemical exposure. A second epidural steroid injection was suggested. The second injection was completed on March 31, 2010. There was marginal improvement in the pain complaints. There was less than 10% improvement noted with the second injection. A third epidural steroid injection was sought. While noting the treating provider identified that only two would be endorsed by the Official Disability Guidelines. A third injection was completed.

The treating provider submitted for an IDET procedure knowing that this would not be certified. As of August 16, 2010, there was a progress note indicating that the primary treating physician was "waiting for the denial letter." A neurosurgical consultation was sought.

Dr. completed a required medical evaluation and noted that physical therapy modalities and medications have been in place for approximately 8 years. There was no evidence of significant improvement other than temporary periods of waning of symptoms. Dr. also felt that there was excessive use of medications in this case. Nonprescription medications were felt to be appropriate for this lady.

The non-certification for the IDET procedure is noted. It was noted that the appropriate psychological testing, discography and other requirements for this procedure had not been met. The request for reconsideration was also not certified.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

**RATIONALE:**

As noted in the Division mandated Official Disability Guidelines IDET is "Not Recommended. Also known as intradiscal electrothermal annuloplasty. *Proposed indications:* The procedure is suggested for discogenic pain that is non-radicular and that has not responded to conservative treatment as an alternative to a fusion procedure. *Mechanism of discogenic pain:* The exact mechanism of discogenic pain remains unknown but is presumed to relate to internal disc disruption. It is hypothesized that painful discs are the result of repetitive injury and subsequent repair. Radial annular tears are thought to allow the matrix substance of the nucleus pulposus to migrate and induce nerve in-growth into the demyelinated regions. (Kloth, 2008) *Mechanism of action of the procedure:* Involves inserting an intradiscal catheter radiologically into the outer posterior or posterolateral annulus across a previously identified tear. The precise mechanism of action of the procedure remains uncertain. The proposed goals of the treatment are to remove unwanted tissue, create a seal to limit expression of the matrix components, shrink collagen tissue and destroy nociceptors. (Derby, 2008)"

The ODG also noted, "IDET is Not Recommended by the ODG." Patient selection criteria for IDET if provider & payor agree to perform anyway:

- Unremitting, persistent low back pain of at least 6 months continuous duration;
- Other potential structural causes of chronic low back pain have been excluded;
- There is no evidence of primary radicular pain or radiculopathy;
- A MRI has been performed demonstrating disc pathology of the posterior annulus at no more than two levels without evidence of a neural compressive disorder or prior surgery at that level;
- No more than two discs are involved and reduction of disc height is no more than 50%;
- There is evidence of lack of satisfactory improvement with a comprehensively applied non-operative care program, including: back education, activity modification, progressive intensive exercise, a trial of manual physical therapy, and oral anti-inflammatory medication;
- If a patient fails to improve with aggressive treatment psychiatric screening should be undertaken. This includes independent neuropsychiatric screening using a validated instrument

(with the gold standard being the MMPI-2). The psych screen should include an evaluation for potential dependence/addiction if medications known for dependence are in use (such as opioids or benzodiazepines). See [Psychological evaluations, IDDS & SCS](#) (intrathecal drug delivery systems & spinal cord stimulators);

- If the patient fails to improve with aggressive non-operative care and the above criteria are met, discography is undertaken. The discogram has to reproduce concordant pain at low pressurization (i.e. at less than 50 psi above opening pressure) at one or more levels with adjacent control levels not demonstrating pain reproduction. Concordant pain reproduction is defined as reproduction of the patient's typical low back pain symptoms.

Therefore, due to the ODG criteria not being met; this procedure is not certified as not meeting medical necessity.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES