

# Clear Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/20/2010

**IRO CASE #:**

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

Outpatient Lumbar Discogram w/ CT 62290 72295 72131

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

M.D., 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**

Official Disability Guidelines and Treatment Guidelines

CT Brain: 01/04/08

MRI of lumbar spine: 07/16/08, 11/11/09

Dr. Office notes: 12/14/07, 08/06/08

Dr. Physical Medicine and Rehab Evaluation: 06/30/0

Dr. Rehab, office notes: 01/25/10, 02/15/10, 03/12/10, 05/07/10, 05/14/10, 05/28/10, 06/04/10, 06/23/10

Dr. Initial Evaluation: 01/27/10

Left L4-5 and L5-S1 medial branch nerve blocks: 02/01/10

Right L4-5 and L5-S1 medial branch nerve block: 02/25/10

Radiofrequency neurotomies of the left L4-5 and L5-S1 medial branch nerves: 04/07/10

X-ray films: 07/27/10

C Peer Review: 10/19/1, 11/17/10

10/22/10, 11/17/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who sustained a work related injury to his low back on xx/xx/xx when the truck he was driving was involved in a motor vehicle accident. The claimant has complained of low back pain with radiation into his left and right thighs since that time. The claimant had medial branch blocks to L4-5 and L5-S1 bilaterally. He obtained pain relief for about 1½-months after the blocks to his left side. The claimant underwent radiofrequency neurotomies of the left L4-5 and L5-S1 medial branch nerves on 04/07/10 but did not get any relief from the procedure. When the claimant saw Dr. on 07/27/10, plain x-ray films showed

evidence of grade I spondylolisthesis at L5-S1 with a mild curvature convex to the left. Dr. recommended a discogram. This was noncertified in a peer review dated 10/19/10 as the medical records submitted for review had limited objective documentation that the patient had indeed failed in the conservative management such as physical therapy and chiropractic therapy. A second peer review dated 11/17/10 also noncertified the discogram as current guidelines do not recommend this procedure, and the medical information submitted for review did not indicate the presence of red flags or severe or progressive neurologic deficit to warrant the medical necessity of the diagnostic modality.

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

The requested Outpatient Lumbar Discogram w/ CT 62290 72295 72131 is not medically necessary based on review of this medical record.

This is a gentleman who has had ongoing back pain since an injury in xx/xx/xx. There are multiple medical records to review to include an 11/11/09 MRI lumbar spine report that describes degenerative disc disease L5-S1 with mild anterior spondylolisthesis. This claimant has undergone multiple medial branch blocks with ongoing continued pain, and a discogram was requested to determine whether or not the claimant has low back pathology, which might benefit from surgery. The Official Disability Guidelines indicate that discography is not a recommended procedure. There are no good long-term studies in the orthopedic literature indicating that the use of a discogram is a good predictor for surgical success, and therefore, it is not thought to be a useful test to do and use for surgical planning. Therefore, since a discogram is not going to give any new information on which to determine future treatment to include surgery, then there is no medical necessity for the requested Outpatient Lumbar Discogram w/ CT 62290 72295 72131.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Updates. Low Back

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

Back pain of at least 3 months duration

Failure of recommended conservative treatment including active physical therapy

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)

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)

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

Briefed on potential risks and benefits from discography and surgery

Single level testing (with control) (Colorado, 2001)

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)