



Notice of Independent Review Decision

DATE OF REVIEW: 12/17/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection for Spine Disc X-Ray
X-Ray of Lower Spine Disc

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

Board Certified in Orthopaedic Surgery
Certified in Evaluation of Disability and Impairment Rating -
American Academy of Disability Evaluating Physicians

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Injection for Spine Disc X-Ray – UPHELD
X-Ray of Lower Spine Disc – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Employer's First Report of Injury or Illness, xx/xx/xx
- Evaluation, Medical Center, 04/01/09, 04/13/09
- DWC Form 73, M.D., 04/01/09, 04/15/09
- Cervical/Lumbar Spine X-rays, M.D., 04/03/09
- Lumbar Spine MRI, Dr. 04/09/09
- Letter of Medical Necessity, Medical Center, 04/15/09
- DWC Form 73, D.C., 04/28/09, 05/12/09, 05/27/09, 06/10/09, 06/24/09, 07/08/09, 07/31/09, 08/21/09, 09/21/09, 10/21/09, 11/20/09, 05/24/10, 10/20/10
- Request for Authorization of Reasonable and Necessary Services, Dr. 05/13/09
- Conductive Garment, Dr. 05/13/09
- Supply Order, Dr. 05/13/09
- Evaluation, D.O., 05/14/09
- Outpatient Consultation Encounter, M.D., 06/15/09
- Procedure Note, Dr. 06/25/09
- Cervical Spine MRI, 07/21/09
- Established Patient Encounter, Dr., 07/30/09
- Letter of Medical Necessity, 08/05/09
- Electrodiagnostic Study, D.O., 08/08/09
- Correspondence, Dr. 08/20/09, 09/21/09
- Medical Record Review, M.D., 04/24/09
- Medical Record Review, M.D., 08/13/09
- Initial Visit, M.D., 09/03/09
- Radiographic Reading, Dr. 09/03/09, 10/27/09
- Upper EMG and Nerve Conduction Study, M.D., 09/24/09, 07/14/10
- Required Medical Evaluation (RME), M.D., 09/30/09
- DWC Form 73, M.D., 10/06/09
- Encounter Note, Dr. 10/07/09
- DWC Form 73, Dr. 10/27/09
- Pre-Surgical Screening, Dr. 10/27/09
- MMPI, Unknown Provider, 12/11/09
- Initial Diagnostic Screening, M.S., L.P.C., 01/01/10
- Treatment Progress Note, Ms. 02/26/10, 03/03/10, 03/10/10, 03/16/10, 06/25/10
- Designated Doctor Evaluation (DDE), M.D., 03/15/10, 05/21/10
- DWC Form 73, Dr. 03/15/10
- Treatment Progress Report, Ms. 03/17/10, 10/25/10
- Follow up Visit, Dr. 10/07/09, 10/27/09, 03/16/10, 05/10/10, 06/01/10, 07/19/10, 11/18/10
- Interim Note, Dr. 06/01/10
- Pre-Authorization, Dr. 06/30/10
- Lumbar Spine, MRI, M.D., 07/05/10
- Peer Review, M.D., 08/30/10

- Functional Capacity Evaluation (FCE), P.T., 09/22/10
- Request for Pre-Authorization, Dr. 09/24/10
- Denial Letter, 10/08/10, 10/18/10
- Correspondence, P.C., 12/06/10
- Letter of Medical Necessity, Dr. Undated
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured on xx/xx/xx when he fell off a forklift landing on his spine. Initial MRI's showed spondylosis of the lower cervical spine and disc space narrowing at the L5-S1 level compatible with disc disease of the lumbar spine. A second MRI of the cervical spine showed a herniation at C3-C4, C4-C5, C5-C6 and C6-C7. An electrodiagnostic study showed acute right L5 radiculopathy with active denervation. A second EMG/NCV study showed an indication of acute radiculopathy in the C6 and C7 motor roots with the left side predominating with an equivocal C5 involvement as well. A Designated Doctor Evaluation (DDE) performed on 03/15/10 placed the patient at Maximum Medical Improvement as of 03/15/10 with a 10% whole person impairment rating. Another EMG/NCV study performed on 07/14/10 showed an indication of mild bilateral L4 radiculopathy and more acute bilateral L5 and S1 radiculopathy with the left side predominating. A discogram was then requested. The patient's current medications were listed as Arthrotec 75 mg twice per day, Soma 250 mg three times per day, Voltaren gel, and Tramadol 50 mg three times per day.

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

The ODG does not endorse the use of discography for the determination of surgical levels. Current medical literature indicates that the false positive rate of discography is unacceptably high. This patient is not a surgical candidate, despite Dr. advocacy that he is. This patient will not be best served by a fusion or decompression. Therefore, the recommendation is for an unreliable test (discography is less than 50% predictive according to current medical literature) for a patient that does not require surgical intervention. Therefore, the criteria set forth by the ODG have not been met. Therefore, an injection for spine disc x-ray and x-ray of lower spine disc is neither reasonable nor necessary.

Criteria utilized include the ODG and the current medical literature, especially the articles by Caragee and his co-authors, which demonstrate the futility of discography in this type of patient with significant psychosocial stressors, depression, and no radiculopathy.

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**
- 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 (PROVIDED DESCRIPTION ABOVE)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**
- AMA GUIDES 5TH EDITION**