I-Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: January 10, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar discogram

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
11/22/10, 12/3/10
Chiropractic Center 11/19/10
MD 10/21/10
Healthcare PC 10/22/10
Churchill 9/20/10
Behavioral Health 10/29/10
Imaging (no date)

PATIENT CLINICAL HISTORY SUMMARY
This is a man reportedly injured on xx/xx/xx“when he accidentally twisted his left knee while standing and fell over backwards landing on his tailbone. He states that when he hit there was a definite pop in both his lower back and his left knee with an immediate onset of low-back and left knee pain.” He continues with back pain with left lower extremity pain. He has the diagnosis of a radiculopathy that did not improve with 2 caudal ESIs. The reports described back pain and left lower extremity pain and no specific dermatomal pattern or neurological loss. The MRI showed a disc herniation at L4/5 and L5/S1. A DD exam found no impairment in September 2010. This request is for a discogram prior to a surgical procedure, presumably a spinal fusion. There was no psychological contraindication in the evaluation done in October 2010.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The Official Disability Guidelines do not support the role of the discogram to confirm the presence of discogenic pain. The ODG does acknowledge a role if the intent is for a spinal fusion, and the test may exclude the procedure. However, the records regarding the surgical

procedure to be performed are incomplete as the surgeon's evaluation was not provided. The MRI was not provided. The reviewer finds no medical necessity for Lumbar discogram.

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

[X] 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)