

Wren Systems

An Independent Review Organization
3112 Windsor Road #A Suite 376
Austin, TX 78703
Phone: (512) 553-0533
Fax: (207) 470-1064
Email: manager@wrensystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/13/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Discogram of CT Cervical C4/5-C6/7

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

MD, 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

PATIENT CLINICAL HISTORY SUMMARY

This claimant is a with a reportedly history of neck pain. The claimant was reportedly injured in xxxx when a water soaked ceiling collapsed striking him on the head which resulted in a fall and T7-8 compression fracture. Ongoing neck pain was reported. A second injury occurred in when the claimant developed an exacerbation of neck and shoulder pain while pulling himself up onto a using his left arm. Diagnoses included the compression T7-8 fracture, cervical spondylosis and neck pain with degenerative narrowing C6-7 with neural foraminal stenosis and minimal spondylolisthesis.

A physician record of 12/22/09 noted the claimant with pain at the base of the neck and status post recent left shoulder rotator cuff repair. Physical therapy and facet injections for diagnostic and therapeutic purposes right C5-6 and C 6-7 were recommended. A right C5-6 and C6-7 facet joint injection followed on 01/22/10 with reported benefit after five days with a decreased pain level and somewhat improved range of motion.

A 06/29/10 physician record noted previous cervical MRI's reviewed and a surgical consult for second opinion recommended. The evaluation dated 07/20/10 revealed the claimant with severe limitations in neck extension and rotation. Neck pain secondary to possible secondary degenerative disc disease was diagnosed. A cervical MRI followed on 08/13/10, which, showed subtle grade I spondylolisthesis C5 on C6 with a broad based posterior disk protrusion and minimal bilateral neural foraminal narrowing C4-5.

A follow up physician record of 08/23/10 noted the claimant with continued neck and bilateral shoulder pain. An evaluation by physical therapy for core stabilization of the neck and cervical discography C4-5 through C6-7 was recommended. A behavioral medical evaluation dated 11/03/10 revealed the claimant cleared for discography and cleared for any spine surgery.

A second opinion consultation was performed on 03/01/11. The claimant was noted to have a fifteen-year history of neck pain with treatments that included pain management with medications, therapy and injections. The consulting physician agreed that a cervical discogram was needed to determine the pain generator. Significant neck pain was again

noted on a 04/08/11 physician visit. The impression was neck pain with degenerative narrowing C6-7 as well as neural foraminal stenosis at C5-6 with minimal spondylolisthesis of 5-6 as well. The claimant was noted to be a candidate for surgical intervention with cervical discography recommended.

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

The Official Disability Guidelines speak to discography in the neck and upper back. In general, the procedure is not recommended. The guidelines clearly outline that the ability of discography “to improve surgical outcomes has yet to be proven”. The guidelines are not satisfied for medical necessity regarding this proposed discographic study. In this case, the reviewer finds there is no medical necessity for Discogram of CT Cervical C4/5-C6/7. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

Official Disability Guidelines Treatment in Worker’s Comp, 16th edition, 2011 Updates Neck and Upper Back: Discography

Not recommended. Conflicting evidence exists in this area, though some recent studies condemn its use as a preoperative indication for IDET or Fusion, and indicate that discography may produce symptoms in control groups more than a year later, especially in those with emotional and chronic pain problems. (Carragee, 2000) (Carragee2, 2000) (Bigos, 1999) (Grubb, 2000) (Zeidman, 1995) (Manchikanti, 2009) Cervical discography has been used to assist in determining the specific level or levels causing the neck pain and, potentially, which levels to fuse; however, controversy regarding the specificity of cervical discograms has also been debated and more research is needed. (Wieser, 2007) Assessment tools such as discography lack validity and utility. (Haldeman, 2008) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. (Cohen, 2005)

Discography is Not Recommended in ODG. See also the Low Back Chapter

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

- o Neck pain of 3 or more months
- o Failure of recommended conservative treatment
- o 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)
- o Satisfactory results from psychosocial assessment (discography in subjects with emotional & chronic pain has been associated with reports of significant prolonged back pain after injection, and thus should be avoided)
- o Should be considered a candidate for surgery
- o Should be briefed on potential risks and benefits both from discography and from surgery
- o Due to high rates of positive discogram after surgery for 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)**