MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: March 29, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar discogram at L1-2, L2-3, L3-4 and L4-5 with post computed tomography (CT) scan (62290, 72295 and 72132).

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

M.D., Board Certified in Orthopedic Surgery.

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)

The requested lumbar discogram at L1-2, L2-3, L3-4 and L4-5 with post computed tomography (CT) scan (62290, 72295 and 72132) is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 3/15/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 3/16/12.
3. Notice of Assignment of Independent Review Organization dated 3/19/12.
4. Medical records from Orthopaedic Center, –dated 2/1/12.
5. Medical records from Medical Centers dated 6/3/11 through 1/20/12.
6. Medical records from Diagnostic Center dated 6/20/11.
7. Medical records from Hospital dated 9/14/11.
8. Medical records from Pain Consultants, LLP dated 8/4/11.
9. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work related injury to her lumbar spine and left wrist on xx/xx/xx, when she was thrown against a door due to turbulence. She was diagnosed with a lumbar strain. Conservative care was initiated and consisted of oral pain medication, anti-inflammatory medications, analgesic medication, formal physical therapy and pain management. A lumbar MRI was performed on 6/20/11 and no apparent bulge or herniation was identified. The patient also underwent a lumbar bone scan, which evidenced no significant degenerative changes or occult fracture. However, minimal scoliosis of the thoracolumbar spine was noted and degenerative uptake was present at the sternomanubrial junction. Aquatic therapy was recommended. The patient was seen on 1/20/12 with no reports in changes to her pain levels. It was indicated that the patient had participated in physical therapy and was still out of work, as there was no light duty available at her work. The patient also reported aching of the midline lumbar spine and lower back pain, which was exacerbated by standing. No radicular pain was noted. The examination revealed no palpable bony or muscular tenderness, no gait abnormalities, no Waddell signs, and the patient's deep tendon reflexes were equal, sensory was intact to light touch and her motor strength was five out of five. The patient was referred to pain management. The patient was seen in consultation by an orthopedic specialist on 2/1/12. The patient reported continued lower back pain into the left side, without radiation into her legs. The patient also reported that her symptoms were increasing in severity, causing depression and sleep disturbance. The provider recommended Flexeril, Norco, Daypro and a lumbar discogram at L1-2, L2-3, L3-4 and L4-5 post computed tomography (CT). The patient has requested authorization for the recommended diagnostic imaging. The Carrier has denied the patient's request as not medically necessary, which is the subject of this review.

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

The Official Disability Guidelines (ODG) specifically states that discography is not recommended. Discography has previously been used as a preoperative evaluation for patients in consideration of surgical intervention of the back, but it was not predicable, and thus, the conclusions were not considered to be valid. Furthermore, in individuals where there are confounding psychosocial issues, discography is clearly not indicated. However, the ODG does state that discography can be a consideration for individuals who are clearly indicated for surgical fusion but for whom a specific level may be considered at risk and/or of concern.

In this particular case, there is no compelling indication to suggest that this patient would be a candidate for surgical fusion, nor is there any indication to suggest that discography is likely to impart any clinical information to assist in the management of her case. Additionally, there is a report that the patient has a history of depression, which raises concerns regarding confounding psychosocial issues. In consideration of all of the information provided, the requested service is not consistent with ODG criteria and is not medically appropriate.

Therefore**,** I have determined the requested lumbar discogram at L1-2, L2-3, L3-4 and L4-5 with post computed tomography (CT) scan (62290, 72295 and 72132) is not medically necessary for treatment of the patient's medical condition.

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 (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**