

# Applied Assessments LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Dec/14/2012

**IRO CASE #:**

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

Discogram Cervical C4-7

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

Anesthesiology/Pain Management

**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 medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Cover sheet and working documents  
Progress notes 05/11/12 and 06/13/12  
Clinic note 07/16/12  
Letter 08/30/12  
Handwritten progress notes 09/26/12  
Clinic notes 09/26/12 and 10/22/12  
Utilization review determination 10/09/12  
Utilization review determination 11/12/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male whose date of injury is xx/xx/xx. Records indicated that he was injured when he was hit on the head with an elevator door. He was status post L4-5 laminectomy. Progress note dated 09/26/12 indicated that the claimant complained of severe pain to the neck radiating to the bilateral shoulders and arms. On examination of the cervical spine, there was loss of lordosis. Upper extremity strength was reported as 5+/5+. Sensation was normal throughout the upper extremities. Reflexes were 2+/4+ throughout the bilateral upper extremities. The claimant was recommended to undergo discogram of the cervical spine.

A request for a cervical discogram at C4-7 was non-authorized per notification of adverse determination dated 10/09/12 noting that the claimant complained of ongoing pain described

as neck pain with upper extremity paresthesias without specific dermatomal distribution. Physical examination was noted to reveal atrophy of the right (?? 5:00), decreased light touch to the bilateral C6 dermatome, no neck tenderness with full range of motion. Upper extremity examination was unremarkable. Range of motion was full without weakness, negative for Phalen's and Tinel's sign. Treatment has included medication, epidural steroid injections, and physical therapy. However, current evidence based guidelines do not recommend discography in the management of neck injuries. Therefore, medical necessity has not been substantiated.

A reconsideration request for a cervical discogram at C4-7 was non-certified per notification of reconsideration determination dated 11/12/12 noting that Official Disability Guidelines do not recommend discography. The guidelines state that selection criteria for discography, if it is to be performed, requires: neck pain for 3 or more months, failure of recommended conservative treatment, MRI demonstrating 1 or more degenerative disc as well as 1 or more normal-appearing disc to allow for an internal control injection, and satisfactory results from a psychosocial assessment. The patient should be considered a candidate for surgery and should be briefed on potential risks and benefits of discography and surgery. Due to high rates of positive discogram after surgery for disc herniation, there should be potential reason for non-certification. It was noted that there was still insufficient documentation submitted to indicate the need for discography in the cervical spine. It was noted that the claimant had ongoing complaints of pain despite epidural steroid injections and medication management. However, no MRI was submitted for review to demonstrate 1 or more degenerated discs as well as 1 or more normal-appearing discs. Also, there was not psychological evaluation submitted to indicate that the claimant would be a good candidate for discography. Therefore, the request was non-certified.

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

The claimant sustained an injury on 06/04/10. He has ongoing complaints of neck pain with bilateral right greater than left upper extremity paresthesia without specific dermatomal distribution. Records indicate that the claimant failed a course of conservative care including therapy, epidural steroid injections, and medication management. The most recent examination revealed no evidence of motor, sensory, or reflex deficits in the bilateral upper extremities. Reference is made to MRI of the cervical spine dated 07/07/11, but no radiology report was submitted for review. Per Official Disability Guidelines, discography is not recommended as medically necessary as a preoperative indication based on recent high-quality studies which question the diagnostic value of discography. Its ability to improve surgical outcomes has yet to be proven. If discography is to be performed anyway, patient selection criteria include the following: neck pain for 3 or more months, failure of recommended conservative treatment, MRI demonstrating 1 or more degenerative disc as well as 1 or more normal-appearing disc to allow for an internal control injection, and satisfactory results from a psychosocial assessment. The patient should be considered a candidate for surgery and should be briefed on potential risks and benefits of discography and surgery. No preoperative psychological evaluation was documented. The request for cervical discography at C4-7 does not meet ODG criteria and is not supported as medically necessary based on the clinical data submitted for review.

**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)