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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/17/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar discogram L2-3, L3-4 with post CT scan

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that medical necessity for lumbar discogram L2-3, L3-4 with post CT scan cannot be established and prior denials are upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 07/27/12-10/26/12
Procedure note 09/24/12
Electro-diagnostic studies 08/21/12
Prior reviews 10/18/12 and 11/08/12

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who sustained an injury on xx/xx/xx and has been followed for complaints of low back pain and neck pain radiating into the left upper extremity and left lower extremity. The patient also reported numbness and tingling in the left arm and hand. The patient was initially evaluated on 07/27/12. The patient denied any upper extremity or lower extremity weakness. Medications included Ultram and Naprosyn and Flexeril. Physical examination revealed no clear focal neurological deficits. There was limited range of motion in the neck and low back and straight leg raise testing was reported to reproduce radicular symptoms. Electro-diagnostic studies on 08/21/12 reported evidence of a left L5-S1 radiculopathy. The patient was recommended for epidural steroid injections and the patient underwent a selective nerve root block on the left at L5 on 09/24/12. Follow up on 10/11/12 stated that the patient had approximately 30% relief of symptoms with the selective nerve root block form 09/12. The patient was considering surgical intervention. Physical examination at this visit was unchanged from prior evaluations. The patient was recommended for lumbar discography at L2-3 and L3-4. Although no imaging studies were provided for review, CT myelogram studies were stated to show abnormalities at the L3-4 level. Follow up on 10/26/12 again did not identify any significant changes on physical examination. The request for lumbar discography at L2-3

and L3-4 with a post-discogram CT was denied by utilization review on 10/18/12 as clinical literature did not support the use of discography and there was no indication from the clinical notes to support exceeding guideline recommendations. The request was again denied by utilization review on 11/08/12 due to lack of evidence of pathology at the requested levels that would reasonably require discography.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Discography would not be supported by current evidence based guidelines which do not recommend the procedure secondary to high quality clinical studies which significantly question the efficacy of the procedure and its ability to determine appropriate levels for possible surgical intervention. These clinical studies have shown that operative outcomes on the basis of discography results are typically poor. The clinical documentation provided for review does not support exceeding guideline recommendations. There is no indication that the patient has reasonably exhausted all other attempts at identifying pain generators. The electro-diagnostic studies revealed evidence of pathology in the lower lumbar levels, however. There is no imaging evidence of any pathology in the upper lumbar levels that would reasonably benefit from discography. Additionally, no psychological evaluations were provided for review clearing the patient for a discography procedure. Given the lack of any objective evidence to support exceeding guideline recommendations regarding discography, it is the opinion of the reviewer that medical necessity for lumbar discogram L2-3, L3-4 with post CT scan cannot be established and prior denials are upheld.

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)