

SENT VIA EMAIL OR FAX ON
Feb/16/2012

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/15/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Discogram CT L3-4 L4-5 62290X2,72295.26X2, 72132

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

Orthopedic spinal surgeon, practicing neurosurgeon

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

OD Guidelines

Request for IRO dated 01/30/12

Utilization review determination dated 01/10/12

Utilization review determination dated 01/24/12

Behavioral medicine evaluation dated 12/30/11

Clinical records Dr. dated 01/24/12, 12/19/11

Clinical records Dr. dated 12/09/11, 11/11/11, 10/06/11, 09/06/11, 08/02/11, 07/01/11, 05/25/11, 05/04/11, 04/21/11, 03/28/11, and 03/22/11

Clinical records Dr. dated 10/11/11

Clinic note Dr. dated 09/22/11

MRI lumbar spine dated 05/02/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx.

He presents with low back pain radiating down bilateral lower extremities with numbness and

paresthesias in S1 distribution. The injury occurred while lifting heavy grease head weighing approximately 100 lbs. While he was bent forward partially crouched position holding this heavy object he developed pain in low back that persisted. The claimant was subsequently evaluated by Dr. on date of injury. On physical examination he has tenderness on L4-5 and L5-S1 levels, limited lumbar range of motion, palpable spasms, reflexes 2/4 and symmetric and straight leg raise is positive but primarily triggers muscle spasms in low back. Strength and sensation is otherwise normal. He was provided oral medications and placed on light duty and referred for physical therapy. Records indicate the claimant continued under care of Dr.. He was referred for MRI on 05/02/11. This study notes degenerative disc changes at L3-4 and L4-5, right central inferior extrusion of disc material at L4-5 that abuts the proximal descent of right L5 nerve root. There is no high grade narrowing of spinal canal and neural foramina. Records indicate the claimant failed to improve with conservative treatment. He was later referred to Dr. on 09/22/11 for evaluation of epidural steroid injections. The claimant was seen by Dr. on 10/11/11 who recommended the claimant undergo multilevel lumbar discography. The claimant was subsequently referred to Dr. on 12/19/11. Dr. notes the claimant underwent 2 epidural steroid injections which did not give him any relief. He reported back pain was 8/10. On physical examination he is noted to be 5'11" tall and weighs 210 lbs. Reflexes of knee and ankles are symmetric. Sensation to light touch is normal. Motor strength is 5/5. Sitting root test and straight leg raise produces low back pain. Faber's test is negative. He can flex at fingertip to below knee level. He has some pain with extension. MRI is discussed. The claimant is noted to have no instability on flexion or extension. The claimant is noted to have low back pain with bilateral leg pain without clear signs of radiculopathy. He is recommended to rule out discogenic syndrome with failure of extensive conservative treatment. Dr. opines that the claimant's problems are emanating from the L3-4 and L4-5 levels and recommends confirmatory discography the claimant was referred for psychiatric evaluation and cleared.

The initial review was performed by Dr. on 01/10/12 who non-certified the request noting that the Official Disability Guidelines do not recommend discography. He notes that if the patient and the payer agree there should be back pain of at least three months duration failure of recommended conservative care and MRI demonstrating one or more degenerative discs as well as one or more normal appearing discs to allow for internal control and should be intended as a screening tool to assist in surgical decision making. Dr. notes that the medical records he was provided do not include an MRI to correlate the physical examination findings with imaging studies and to demonstrate that there is a control disc available.

The subsequent appeal request was reviewed on 01/24/12 by Dr. who non-certified the request and acknowledges a prior determination of non-certification based on missing criteria including significant physical therapy for this patient in the recent past and the MRI to correlate physical findings with imaging studies and to demonstrate that there is a control disc available. He notes that there he reports that there remains no documentation of significant physical therapy for this patient in the recent past and the MRI to correlate the physical examination findings with imaging studies to demonstrate the control disc is not available or is available.

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

The request for lumbar discography is supported as medically necessary. The submitted clinical records or is medically necessary and the previous utilization review determinations are overturned the submitted clinical records indicate that the claimant has evidence of pathology significant pathology at the L4-5 and L5-S1 levels. The records indicate clearly that the claimant has undergone extensive conservative management which included physical therapy and epidural steroid injections without improvement. The submitted MRI indicates normal disc from T12-L1 through L2-3. There's evidence of disc degeneration at the L3-4 level with more pronounced findings at L4-5 and L5-S1 evidence of a disc herniation with extrusion at the L4-5 level. The claimant has failed all conservative management he's been cleared by behavioral health he clearly has a surgical lesion at the L4-5 level requester

remains that there are additional levels. As such the request meets medical necessity and the claimant meets requirements per the Official Disability Guidelines for the performance of this procedure.

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)