

# US Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Sep/23/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** lumbar spine CT scan and discogram @ L3-4, L4-5 and L5-S1

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Anesthesiology and Pain Medicine

**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 this reviewer's opinion that medical necessity is not established for the requested lumbar spine CT scan and discogram @ L3-4, L4-5 and L5-S1 and the prior denials are upheld.

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

ODG - Official Disability Guidelines & Treatment Guidelines  
Letter of medical necessity dated 02/22/13  
Lumbar exercise reports, undated  
Treatment plan review dated 03/11/13  
Functional capacity evaluation dated 01/18/13  
Chronic pain management reports dated 03/28/13  
Designated doctor evaluation dated 07/09/13  
MRI of the lumbar spine dated 10/17/12  
EMG report dated 01/02/13  
Procedure reports dated 02/05/13 – 06/18/13  
Clinical reports dated 01/16/13 – 08/19/13  
Clinical reports dated 02/20/13 – 06/17/13  
Prior reviews dated 07/25/13 & 08/28/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who sustained an injury on xx/xx/xx. The patient developed pain in the low back. The patient was provided physical therapy in September of 2012 and MRI studies of the lumbar spine completed on 10/15/12 demonstrated multi-level disc desiccation at L3-4 and L4-5 with circumferential disc bulging and facet arthrosis contributing to foraminal stenosis. There was a disc protrusion at L5-S1 noted contributing to foraminal stenosis. Electrodiagnostic studies completed on 01/02/13 showed evidence of a mild L4 and L5 radiculopathy. The patient was provided an epidural steroid injection at L5-S1 on 02/05/13 with repeat injections performed on 04/24/13. The patient then underwent a selective nerve root block at L4-5 and L5-S1 on 06/18/13. The clinical report on 07/19/13 indicated the patient had minimal response to the most recent

selective nerve root blocks completed on 06/18/13. The patient continued to report complaints of low back pain and physical examination demonstrated positive straight leg raise findings with pain on lumbar range of motion. There was decreased sensation in the right lower extremity in an L5 dermatome. The patient was recommended for provocative discography from L3 to S1 with a post discogram CT. Follow up on 08/19/13 indicated the patient continued to have complaints of low back pain. Overview of the patient's prior epidural steroid injections showed the most relief with the primary injection from February of 2013 with subsequent reduced levels of relief with the subsequent injections. The patient was again recommended for provocative discography.

The request for lumbar discography from L3 to S1 with post discogram CT was denied by utilization review on 07/25/13 as the procedure was not recommended by current evidence based guidelines as there were high quality clinical studies which question the efficacy of the study. There was also no documentation regarding psychological evaluations.

The request was again denied by utilization review on 08/28/13 as there was no psychological evaluation available for review regarding clearance for the procedure.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has continued to report chronic low back pain with radicular features and loss of sensation in the lower extremities. MRI studies did show multi-level degenerative disc disease most significant at L3-4 and L4-5. In regards to discography, the procedure is not will supported in clinical literature. There are very good high quality studies which significantly question the efficacy of this procedure. Further clinical literature indicates that the outcomes from lumbar fusion on the basis of discography are typically very poor. The clinical documentation provided for review does not support exceeding guideline recommendations that do not recommend discography. There is still no documentation regarding a psychological evaluation which has found that the patient is an appropriate candidate for a diagnostic test such as lumbar discography. Additionally, given the review of the imaging study, there is multi-level pathology from L3 to S1 without a good control level. Furthermore, current evidence based guidelines do not recommend discography of more than 2 levels. As there is no indication from the clinical records that the request for discography exceeds guideline recommendations or is an outlier to guideline recommendations, it is this reviewer's opinion that medical necessity is not established for the requested lumbar spine CT scan and discogram @ L3-4, L4-5 and L5-S1 and the 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)