

# Applied Assessments LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Aug/19/2013

**IRO CASE #:**

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

Outpatient CT discogram to the Lumbar spine at L4-S1

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

Board Certified 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)

**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  
Physical therapy evaluation dated 09/18/12  
MRI of the lumbar spine dated 07/20/09  
Radiographs of the lumbar spine dated 05/10/12  
MRI of the lumbar spine dated 05/19/12  
Clinical reports dated 11/20/12 – 07/12/13  
Psychological evaluation dated 12/07/12  
Prior reviews dated 06/17/13 & 07/05/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained an injury on xx/xx/xx. It appears the patient did have prior surgical procedures performed from L3 to S1 consistent with decompressive laminectomy procedures. It was noted that the patient was being followed for ongoing chronic pain and recommended for individual psychotherapy in December of 2012. On 07/12/13, the patient continued to have complaints of low back pain radiating to the bilateral lower extremities. Physical examination was limited and within normal limits. It does appear that the patient had an intrathecal pain pump placed which was expected to require an infusion increase.

The submitted request for a lumbar CT discogram from L4 to S1 was denied by utilization review on 06/17/13 as guidelines did not support the procedure.

The request was again denied by utilization review on 07/05/13 as there was no documentation to ascertain the patient's pain generators or that there was a recent physical or neurological evaluation.

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

The patient has had a long history of chronic low back pain with multiple surgical procedures including decompressive lumbar laminectomy from L4 to S1. Per current evidence based guidelines, discography is not a recommended procedure as there are high quality clinical studies with significantly question the efficacy of the procedure's ability to identify pain generators that would result in good postoperative outcomes. In this case, there are no indications to exceed these recommendations. The requested levels for discogram are at levels that have undergone previous operations to include lumbar decompression. Therefore, any results per the discography would technically be invalid due to the prior operative changes. Furthermore, there is no documentation to establish that other methods have been used and exhausted in order to determine the patient's pain generator. Also, there was no recent psychological evaluation indicating that the patient was an appropriate candidate for discography. As there are no findings to support that the patient should exceed the general recommendations regarding discography in current evidence based guidelines, it is this reviewer's opinion that medical necessity is not established 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)