

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/13/2013

IRO CASE

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar discogram L2-L5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified Neurological 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 this reviewer that medical necessity for lumbar discogram L2-L5 is not established

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes Dr 04/12/11-12/11/12
Operative report 12/01/11
MRI cervical spine 06/06/12
Interventional pain management reports 09/21/12-12/19/12
MRI lumbar spine 12/03/12
Prior reviews 01/14/13 and 01/18/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury at the beginning of xx/xx. The patient was initially followed for complaints of neck pain radiating into the upper extremities and the patient underwent cervical fusion and underwent cervical decompression at C2-3 and C6-7 with exploration of fusion from C3 to C6 and extension of fusion to C6-7 on 12/01/11. Post-operatively, the patient was seen by Dr. on 12/11/12 with complaints of low back pain radiating to the lower extremities bilaterally. MRI showed disc herniations at L3-4 and L4-5. The patient was recommended for MRI of the lumbar spine in 09/12 which was performed on 12/03/12 and revealed multiple levels of disc height loss from L1 to S1. There was retrolisthesis of L2-3 and L3-4 and L4-5. There was moderate compression of the left L4-5 nerve roots within the L4-5 disc interspace. Follow up with Dr. on 12/11/12 stated that the patient continued to have low back pain radiating to the lower extremities, right worse than left. Physical examination was unchanged and the patient was again recommended for discography and post-discogram CT. The request for lumbar discography from L2 to S1 and from L2 to L5 was denied by utilization review on 01/14/13 as current evidence based guidelines did not recommend discography. The request was again denied by utilization review on 01/18/13 as guidelines did not recommend discography and there was no evidence or documentation regarding psychological evaluations supporting the

request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient was recommended for lumbar discography to identify pain generators. Clinical documentation provided for review does not support exceeding guideline recommendations which do not recommend the use of discography. Current evidence based guidelines indicate that there are high quality clinical studies which significantly question the efficacy of discography and its ability to identify pain generators for surgery. Clinical studies indicate that post-operative results following discography procedures are generally very poor. The clinical documentation provided for review does not support exceeding guideline recommendations regarding discography. From the clinical documentation provided for review, there is no indication that the patient has reasonably exhausted other methods of determining pain generators. The patient has recent imaging studies and there is no psychological evaluation provided for review as indicated by guidelines. As the clinical documentation provided for review does not support exceeding guideline recommendations regarding discography, it is the opinion of this reviewer that medical necessity for lumbar discogram L2-L5 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)