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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Discogram X C5/6, C6/7

Interp X 3 IV sedations

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

Orthopedic Spine 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)

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
Request for IRO dated 12/10/12
Receipt of request for IRO dated 12/11/12
Utilization review determination dated 10/29/12
Utilization review determination dated 11/30/12
MRI cervical spine dated 03/07/12
EMG/NCV study dated 06/22/12
Clinical records dated 08/06/12, 09/06/12, and 10/04/12
Psychiatric evaluation dated 09/14/12
Peer-to-peer results dated 10/29/12
Addendum dated 11/01/12
Letter dated 11/07/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who is reported to have sustained work-related injuries on 01/06/12. On that day, he was employed as a baggage handler. An unloaded baggage cart began to roll down a slide grade. The claimant was holding onto the cart and sustained a traction injury. He was seen at Concentra Medical Center and received oral medications and physical therapy. He had an improvement with his shoulder pain but continued to have cervical pain. The record includes a MRI of the cervical spine dated 03/07/12. This study

notes moderate left neural foraminal narrowing at C3-4. There is a central right paracentral disc protrusion at C5-6 which effaces the ventral thecal sac and indents the ventral cord. The claimant was referred for electrodiagnostic studies on 06/22/12. This study finds no evidence of cervical radiculopathy. There was moderately severe carpal tunnel syndrome on the right and mild carpal tunnel syndrome on the left.

On 08/06/12 the claimant was referred. It is noted that the claimant had complaints of cervical pain and had undergone 2 courses of physical therapy. The claimant was seen by a pain management physician, who requested cervical epidural steroid injections which were not approved under utilization review. On physical examination, deep tendon reflexes were 2+ and symmetric; motor strength was intact. Roos test was positive bilaterally for hand numbness. A right Spurling's created an audible popping sound and increased cervical pain without radiculopathy. Cervical traction reduced his pain. There was slight hypotonicity bilaterally with tenderness bilaterally at the cervical musculature. There were no sensory deficits and range of motion of the cervical spine was within normal limits. It is reported that MRI of cervical spine dated 03/07/12 reveals a C5-6 right central disc protrusion of 4.6 mm effacing the ventral thecal sac and indenting the ventral cord. At C6-7 there is disc desiccation and mild posterior osteophytes. Flexion and extension radiographs do not reveal any instability. Records indicate that the claimant underwent a urine drug screen which was positive for THC which was not consistent with his prescribed medication profile. He was noted to be performing a home exercise program. He was recommended to be placed in a soft collar, to undergo a trial of a TENS unit, and to undergo cervical discography at C4-5, C5-6, and C6-7. The claimant was referred for a preoperative psychiatric evaluation on 09/14/12. There were no contraindications noted. Per clinical note dated 10/04/12, the claimant had previously been denied the request for lumbar discography as he had not had a preoperative psychiatric evaluation. He is noted to be a good candidate per the last submitted clinical note. The claimant was again recommended to undergo cervical discography.

The initial review was performed on 10/29/12. non-certified the request. essentially found that current evidence based guidelines did not support the use of discography in the evaluation/management of the cited injury/condition.

The appeal request was reviewed. upheld the previous denial noting that at the time, there were no objective findings on physical examination which would support the medical necessity for surgery. Therefore, the performance of a discogram would not be medically necessary. He further noted that there are no consistent evidence-based guidelines supporting the use of discography for the evaluation and management of a cervical cord injury/condition.

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

The request for cervical discography at C5-6 and C6-7 with interpretation and IV sedations is not supported as medically necessary. Therefore, the prior utilization review determinations are upheld. The Official Disability Guidelines are very clear that the performance of cervical discography is controversial. The data yielded from these studies is largely subjective and generally does not provide any substantive or consistent information that would alter the course of the claimant's treatment. Therefore, based upon current evidence based standards, the request cannot be supported as medically necessary and the prior determinations 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)