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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/08/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Discogram L4/5 with Post CT under anesthesia with fluoro guidance

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

Anesthesiologist 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 05/16/13
Utilization review determination dated 05/31/13
Precertification request dated 05/13/13
Progress last procedure note dated 05/08/13
Psychological evaluation dated 03/01/13
Precertification request dated 05/24/13
Letter of reconsideration dated 05/21/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. The mechanism of injury is not described, but the claimant is noted to have several low back surgeries. Per the progress note dated 05/08/13, he complains of low back pain with bilateral lower extremity pain, numbness, and tingling to the feet. The claimant reportedly underwent a myelogram which revealed L4-5 pathology. He underwent an intrathecal narcotic pump trial which provided no pain relief whatsoever. He has a spinal cord stimulator in place and would like it removed and replaced with a different brand. The claimant reports the current stimulator is not working. Current medications were listed as Duragesic patch; Lortab; Lyrica; and Zanaflex. On examination, the claimant was reported to be 5 feet 9 inches tall and 234 lbs. Back examination reported normal spinal curvature. There was midline spinal tenderness to the lumbar spine; right greater than left paralumbar tenderness. Range of motion testing reported flexion with fingers to the knee; extension moderately decreased; lateral bending

moderately decreased; rotation moderately decreased. Neurologic exam reported normal and symmetric lower extremity deep tendon reflexes with strength and sensation intact. Straight leg raise was positive for low back pain. A psychological evaluation performed on 03/01/13 for a preoperative evaluation for an implantable device provided psychological clearance without reservations for an implantable device.

A request for lumbar discogram at L4-5 with post CT under anesthesia with fluoro guidance was non-certified on 05/16/13 noting that Official Disability Guidelines indicate that recent studies on discography did not support its use as a pre-op indication for either IDET angioplasty, or fusion. Discography does not identify the symptomatic high intensity zones, and concordance of symptoms with the disc injected is of limited diagnostic value. Further, it can produce significant symptoms and controls more than a year later.

A reconsideration/appeal request for discogram at L4-5 with post CT under anesthesia with fluoro guidance was determined to not meet medical necessity guidelines per review dated 05/31/13 noting that the psychological evaluation on 03/01/13 indicated the claimant had a spinal cord stimulator placed in 2009. The claimant was provided psychological planners for an implantable device. It is noted the claimant indicated he would proceed with lumbar fusion at L4-5 if approved for the procedure. Physical examination demonstrated decreased range of motion of the lumbar spine, with no neurological deficits identified. On previous review, the reviewer opined that the claimant has had an extensive amount of treatment to include multiple surgical procedures and now has chronic low back pain. The claimant was not an appropriate candidate for lumbar discography, and the current reviewer agreed with the prior denial. The claimant does not meet any of the guideline indications for lumbar discography. The reviewer noted that the claimant has already had multiple fusion procedures performed and is now on pain management. He has completed tertiary levels of pain management to include a spinal cord stimulator implant and failure of IDDS trial. It was also noted that the psychological consult provided for review cleared the claimant for further implantation of devices and not specifically for discography.

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

The claimant is noted to have sustained an injury in xx/xx/xx. He has undergone multiple low back surgeries; however, no operative reports were provided indicating the levels and extent of surgical intervention. References made to myelogram of the lumbar spine which revealed L4-5 pathology, but no radiology reports were provided. Records indicate the claimant currently has a spinal cord stimulator in place. He also underwent a trial of intrathecal narcotic pump which provided no pain relief. The claimant has subjective complaints of low back pain with bilateral lower extremity pain; however, physical examination revealed no motor, sensory, or reflex changes indicative of radicular symptoms in a specific nerve root distribution. The claimant underwent a psychological evaluation which cleared him for an implantable device, but did not specifically address discography. Per Official Disability Guidelines, discography is not recommended as a preoperative indication for IDET or lumbar fusion, noting that concordance of pain is of limited diagnostic value. Official Disability Guidelines further note that discography findings have not been shown to consistently correlate well with findings of a high intensity zone. Based on the clinical information provided, it is the opinion of this reviewer that the request does not meet Official Disability Guidelines criteria and the proposed discogram at L4-5 with post CT under anesthesia with fluoro guidance is not indicated as medically necessary.

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)