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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/05/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: lumbar discogram L5-S1 with fluoro guidance under anesthesia with CT

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

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 is not established for the proposed lumbar discogram L5-S1 with fluoro guidance under anesthesia with CT

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Chiropractic therapy reports 09/14/11-07/30/12
Undated post procedure pain logs
MRI lumbar spine 10/07/11
Clinical records 12/01/11-04/11/13
Procedure note 12/23/11
Independent medical evaluation
Designated doctor evaluation 01/14/12
Electrodiagnostic studies 02/16/12
Behavioral medicine evaluation 02/17/12
Independent medical evaluation 02/24/12
Clinical record 07/02/12
Operative report 09/19/12
MRI lumbar spine 01/28/13
Procedure note 04/02/13
Prior reviews 04/18/13 and 05/06/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who initially sustain an injury on xx/xx/xx. The patient was status post lumbar discectomy at L5-S1 on 09/19/12. Post-operatively the patient was referred for physical therapy and had excellent improvement in the low lower extremity pain following the procedure. The patient reported increasing amounts of mechanical low back pain and an updated MRI of the lumbar spine on 01/28/13 identified post-operative changes consistent with left sided laminotomy and discectomy with non-enhancing soft tissue signal

abnormalities suggesting a disc bulge or possible disc protrusion minimally indenting the ventral thecal sac without neural foraminal or canal stenosis. The patient underwent L4 and L5 bilateral radiofrequency ablation on 04/02/13. No significant improvement was noted with these procedures. Follow up on 04/11/13 reported no evidence of neurological deficits on physical examination. The patient continued to report severe low back pain and discography was recommended. The request for discography at L5-S1 with anesthesia followed by post-discogram CT was denied by utilization review as there was no medical validity to the test in the clinical scenario. The request was again denied by utilization review on 05/06/13 as discography was not recommended for patients who did not meet surgical criteria.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient reported ongoing chronic low back pain with resolution of lower extremity pain following 09/12 discectomy. Per current evidence based guidelines discography procedures are not recommended as there are high quality clinical studies which significantly question the efficacy of the procedure to identify pain generators that may reasonably be improved with surgical treatment. Clinical documentation submitted for review does not support exceeding guideline recommendations regarding discography. The patient has had a prior surgical procedure at L5-S1 and at this time discography at the same level would likely result in invalidated pain responses. Additionally there is no psychological evaluation submitted for review establishing that the patient would be a good candidate for discography. As the clinical documentation submitted for review does not support exceeding guideline recommendations that do not recommend discography, it is the opinion of this reviewer that medical necessity is not established for the proposed lumbar discogram L5-S1 with fluoro guidance under anesthesia with CT 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 KNOWLEDGBASE

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)