

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/23/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient lumbar discogram/CT L5/S1 with control L4/5 and right SI joint injection

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Radiographs of the lumbar spine dated 06/26/13

Clinical report dated 06/27/13

Prior reviews dated 07/09/13 & 07/22/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx while moving boxes. The patient has been followed for complaints of low back pain. Radiographs of the lumbar spine completed on 06/26/13 were shown to be unremarkable. The patient was seen on 06/27/13. Per the clinical report, the patient recently had an exacerbation of low back pain which was constant and reported as severe. Medications noted at this visit included a Medrol dose pack and Keppra. Physical examination at this visit demonstrated tenderness to palpation to the right of the spinous process in the lumbar spine. There was mild weakness noted in the right lower extremity at the extensor hallucis longus, knee, and hip. There was right sided sacroiliac joint tenderness noted. Reflexes were 1 to 2+ and symmetric. Updated MRI studies were recommended as well as the use of a Medrol dose pack.

The request for discography at L4-5 and L5-S1 as well as a right sacroiliac joint injection was denied by utilization review as there was insufficient objective findings to support a diagnosis of sacroiliac joint dysfunction and current evidence based guidelines did not support the role of discography in a post MMI patient.

The request was again denied by utilization review on 07/22/13 as guidelines do not recommend the use of discography due to poor support in clinical literature.

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. The most recent evaluation did show evidence of low back and right sided sacroiliac joint pain; however, no further orthopedic findings for sacroiliac joint dysfunction such as a positive Fabre's sign, stork test, or Ganslen's sign were noted to clearly support a diagnosis of right sided sacroiliac joint dysfunction. Furthermore, there was no documentation establishing that the patient had failed a reasonable course of conservative treatment to address sacroiliac joint symptoms. In regards to the requested L4-5 and L5-S1 lumbar discography, discography is not recommended by current evidence based guidelines as there are high quality clinical studies which significantly question the efficacy of the study in its ability to identify pain generators that may require surgical intervention. Studies also show that surgical outcomes on the basis of discography results are generally very poor. The clinical documentation provided for review does not support that the claimant should exceed guideline recommendations. There is no indication from the clinical records establishing that the claimant has exhausted all reasonable methods of determining pain generators such as selective nerve root blocks or medial branch blocks. There is also no psychological evaluation provided for review indicating that the claimant is an appropriate candidate for the procedure. As the clinical documentation provided for review does not support that the claimant should exceed guidelines recommendations, which do not recommend discography, medical necessity is not established.

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

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)