

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/29/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: pre-discogram surgical psych eval

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Clinical 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 the reviewer that the request for pre-discogram surgical psych eval is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI of the lumbar spine dated 08/05/10
Decision and order dated 10/15/12
Clinical note dated 01/17/13
Peer review dated 01/17/13
Peer review dated 03/04/13
Clinical note dated 04/01/13
MRI of the lumbar spine dated 04/18/13
Clinical notes dated 05/06/13 & 05/20/13
CT myelogram of the lumbar spine dated 05/30/13
Clinical notes dated 06/17/13 & 07/19/13
IRO request form dated 08/06/13
Letter of appeal dated 07/09/13
Adverse determination dated 06/28/13
Adverse determination dated 07/23/13
Letter of appeal dated 08/14/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury regarding his low back. The clinical note dated 01/17/13 details the patient having previously undergone extensive conservative therapy addressing the lumbar complaints. Upon exam, the patient was able to demonstrate 5/5 strength throughout the lower extremities at that time. Reflexes were noted to be intact. The peer review dated 03/04/13 detailed the patient having multiple diagnoses in place. The clinical note dated 04/01/13 details the patient stating the initial injury occurred when she fell backwards. The patient admitted to a loss of

consciousness along with the low back complaints, right shoulder, right hip complaints, as well as multiple contusions. The patient was noted to have undergone extensive conservative therapy with no continued pain. The patient was also noted to have undergone chiropractic therapy as well. The MRI of the lumbar spine dated 04/18/13 revealed mild degenerative spondylosis. Moderate left lateral recess narrowing was noted at the L4-5 level. A small broad based central disc protrusion was noted at L5-S1 without mass effect on the nerve roots or the thecal sac.

The clinical note dated 05/06/13 details the patient able to demonstrate 45 degrees of lumbar flexion with 0 degrees of extension and 5 degrees of bilateral lateral bending. The patient was noted to have a positive straight leg raise bilaterally at 45 degrees. The CT myelogram of the lumbar spine dated 05/30/13 revealed degenerative disc disease at L3 through S1. No definitive spinal canal stenosis was identified at that time. The clinical note dated 06/17/13 details the patient continuing with tenderness upon palpation throughout the lumbar region. Range of motion deficits continued throughout the lumbar spine. Hypoesthesia was noted over the dorsal aspect of the right foot. Hypoactive reflexes were noted throughout the lower extremities. The clinical note dated 07/19/13 details the patient being recommended for an L4-5 fusion.

The utilization review dated 06/28/13 resulted in a denial for a discogram and presurgical psychological evaluation as discograms are not specifically recommended by the Official Disability Guidelines. Additionally, it was unclear at that time as to the specific surgical intervention being requested. Therefore, it was unclear if the psychological evaluation was medically necessary at that time.

The utilization review dated 07/23/13 for a discogram and psychological evaluation resulted in a denial as discograms are noted to be not specifically supported by the current clinical literature. Additionally, it was unclear at that time whether the patient specifically needed a presurgical psychological evaluation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation details the patient complaining of ongoing low back pain despite previous conservative treatments addressing the low back complaints. The use of discography is currently not recommended as these studies have suggested that reproduction of the patient's specific back complaints on injection of 1 or more discs is of limited diagnostic value. Additionally, discography findings have not been shown to consistently correlate well with the findings of other traditional imaging studies. There is mention in the clinical notes regarding the specific operative procedure being proposed for this patient. It does appear that a presurgical psychological evaluation would be indicated for this patient given the proposed fusion within the lumbar region. However, it is unclear if the patient's pain generators have specifically been identified. Given that it is unclear if the patient's pain generators have been sufficiently identified, this request is not indicated. As such, it is the opinion of the reviewer that the request for pre-discogram surgical psych eval is not recommended 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)