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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 4/9/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar discogram with post CT at L3/4, L4/5 and L5/S1 under anesthesia and fluoro guidance.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a lumbar discogram with post CT at L3/4, L4/5 and L5/S1 under anesthesia and fluoro guidance.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

was injured in xx/xxxx in association with lifting. The most recent records including February 21, 2014 noted that the patient had persistent low back pain. Exam revealed decreased lumbar motion with tenderness along with a positive straight leg raise. There was decreased sensation in the L4-S1 dermatomes. A prior lumbar MRI dated 11-26-13 revealed that there was a disc protrusion at L4-5 along with a prior laminectomy and a disc protrusion at L5-S1. Treatments including surgery, medications, ESI and therapy along with restricted activities were noted.

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

Recent studies in the medical literature have not supported reliability of discogram outcomes. This would especially be valid in this patient who was not noted to have either a psychosocial screening prior to such a request and/or considered to be a fusion candidate. The rationale documented in the denials is applicable in this case. Therefore, the procedure is not medically necessary.

Reference: ODG Low Back Chapter patient selection criteria for Discography if provider & payor agree to perform anyway:

- o Back pain of at least 3 months duration
 - o Failure of recommended conservative treatment including active physical therapy
 - o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)
 - o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided)
 - o Intended as screening tool to assist surgical decision making, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria.
 - o Briefed on potential risks and benefits from discography and surgery
 - o Single level testing (with control)
 - o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification
- Indications for imaging -- Computed tomography:
- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit
 - Thoracic spine trauma: with neurological deficit
 - Lumbar spine trauma: trauma, neurological deficit
 - Lumbar spine trauma: seat belt (chance) fracture
 - Myelopathy (neurological deficit related to the spinal cord), traumatic
 - Myelopathy, infectious disease patient
 - Evaluate pars defect not identified on plain x-rays
 - Evaluate successful fusion if plain x-rays do not confirm fusion

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)