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Notice of Independent Review Decision

DATE OF REVIEW: February 11, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One lumbar discogram with post-CT scan (L5-S1 discogram, L4-5 control level, with post CT scan, 62290 x 2; 72295 x 2; 72132).

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

M.D., Board Certified in Orthopedic 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)

The requested one lumbar discogram with post-CT scan (L5-S1 discogram, L4-5 control level, with post CT scan, 62290 x 2; 72295 x 2; 72132) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 1/18/14.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 1/21/14.
3. Notice of Assignment of Independent Review Organization dated 1/22/14.
4. Denial documentation dated 12/19/13 and 1/9/14.
5. Orthopedic report dated 8/30/12, 9/17/12, 10/5/12, 11/13/12, 12/26/12, 2/7/13, 2/22/13 and 12/28/13.
6. Pre-authorization request dated 12/14/13.

7. Procedure Orders undated.
8. Office notes dated 3/12/13, 4/9/13, 5/13/13, 6/7/13, 7/11/13, 8/27/13, 9/9/13, 10/10/13 and 11/7/13.
9. Manual Muscle strength exam lumbar dated 10/10/13.
10. MRI lumbar spine dated 8/30/12.
11. CT scan of L-spine dated 8/23/12.
12. Office visits dated 11/30/12, 12/5/12, 12/10/12, 12/12/12, 12/14/12, 12/21/12, 1/4/13, 1/7/13, 1/11/13, 1/14/13, 1/16/13, 1/18/13 and 1/24/13.
13. Initial rehabilitation evaluation dated 11/16/12.
14. ODG Guidelines: Chapter Low Back.
15. Letter dated 5/29/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx. The patient was seen in clinic on 8/30/12, at which time he reported injuries to his right shoulder, left knee and back. Upon examination, he had tenderness to the thoracolumbar junction and his motor exam was limited by his left knee, which was very tender and had limited range of motion. There was no gross instability. His patellar reflexes were 1+ bilaterally and his Achilles reflexes were 2+. On 5/29/13, imaging studies noted that he had a thoracic magnetic resonance imaging (MRI) and a lumbar MRI which revealed a disc herniation at L5-S1. He had paresthesias along his L5 and S1 distribution bilaterally at that time. On 11/7/13, he returned to clinic and reported continued pain in the lumbar region. He had an antalgic gait at that time and his Achilles reflex was rated at 2/4 bilaterally and there was no clonus noted. Sensation was intact to the lower leg and intact to the upper leg. Faber's test was negative bilaterally, as was Gaenslen's test. The patient's provider has recommended an L5-S1 discogram, L4-5 control level, with post CT scan.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Per the URA on 1/9/14, failure of recent conservative care with physical therapy was not documented.

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

Official Disability Guidelines indicate that the requested discography is not recommended, however if the procedure is to be performed then criteria should be met. These criteria would include documentation of an MRI demonstrating one or more degenerative discs as well as one or more normal appearing discs, as well as satisfactory results from a detailed psychosocial assessment. Based on the records submitted for review, there is no documentation that indicates that a psychosocial evaluation has been performed as a psychosocial evaluation was not submitted for this review. Moreover, the lumbar MRI dated 8/30/12 reveals no significant disc bulge or herniation at L1-2 to L4-5. Spinal canal and bilateral neural foramina were patent. The only pathology seen in the MRI was at L5-S1 where there was a diffuse disc herniation by approximately 4mm, reaching up to the thecal sac. Bilateral neural foramina were mildly narrowed at that level. A computed tomography (CT) scan of the lumbar spine on 8/23/12 revealed alignment of the lumbar spine was normal and the spinal canal was maintained without

fractures or focal bone lesions being present. The disc spaces demonstrated normal height without evidence of significant degenerative changes and the facet joints appeared normal. For this patient, the only pathology seen on imaging has been at L5-S1. Therefore, there would be no need to try to demonstrate pathology at any other level as both imaging studies are negative at other levels. Due to pathology being seen at only one level on the MRI and the CT, and lack of psychosocial evaluation, the requested services are not medically necessary. Additionally, the records do not indicate that the patient has had failure of all conservative measures. In accordance with the above, I have determined that the requested one lumbar discogram with post-CT scan (L5-S1 discogram, L4-5 control level with post CT scan) is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)