

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: 12/31/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Diskography Injection @ L3/4, L4/5, L5/S1 62290, 72295 Lumbar Radiological Supervision and Interpretation 01908, Anesthesia, 77003-Fluoroscopi guidance for needle placement

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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 or not medical necessity exists for each of the health care services in dispute.

Per the *Official Disability Guidelines*, a discogram in general is “not recommended.” It is “intended as a screen for surgery.” There has been no indication that this patient has been approved for surgery at this time. Therefore, per the *Official Disability Guidelines*, discography would not be an appropriate intervention for this patient at this time. The reviewer finds that Lumbar Diskography Injection @ L3/4, L4/5, L5/S1 62290, 72295 Lumbar Radiological Supervision and Interpretation 01908, Anesthesia, 77003-Fluoroscopi guidance for needle placement is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/9/07, 11/21/07
ODG Guidelines and Treatment Guidelines
MD, 5/9/07, 5/24/07, 7/13/07, 7/23/07, 8/17/07, 11/13/07
Dr., 6/6/07
MRI, 10/23/06
, DO, 7/12/07, 7/23/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured while on the job on xx/xx/xx. Since this injury, the patient has been experiencing low back pain which radiates down to his left lower extremity. Since that time, he has received epidural steroid injections which have not been helpful for his pain. He has also been involved in physical therapy. He was evaluated by Dr., a neurosurgeon, who recommended epidural steroid injections and potential nucleoplasty. Dr. went on to state that if “nucleoplasty fails, I am going to probably have to recommend a posterior lumbar interbody fusion at the L4-5 and L5-S1” levels. Since that time, the patient has seen Dr. who has recommended a discogram to see if the patient is a candidate for minimally invasive disc decompression.

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

Per the *Official Disability Guidelines*, percutaneous discectomy or minimally invasive disc decompression is “not recommended.” Therefore, since the request for the discogram is for percutaneous disc decompression, per the *Official Disability Guidelines*, a discogram would not be appropriate at this time. The reviewer finds that Lumbar Diskography Injection @ L3/4, L4/5, L5/S1 62290, 72295 Lumbar Radiological Supervision and Interpretation 01908, Anesthesia, 77003-Fluoroscopi guidance for needle placement is not medically necessary.

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)**