

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:

JUNE 27, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Diskogram, lumbar @ L5-S1, x-ray exam of lower spine, CAT scan of lower spine

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

MD 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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notes, physical therapy, 03/28/06 and 02/12/07
Thoracic spine MRI, 05/05/06
Lumbar spine MRI, 06/19/06
Request for third epidural steroid injection, 01/26/07
Office notes, Dr. 02/12/07, 02/16/07, 02/19/07, 02/22/07, 02/26/07, 03/23/07, 03/30/07, 03/20/07, 04/02/07, 04/06/07, 04/09/07, 04/16/07, 04/23/07, 05/21/07 and 06/24/07

EMG, 02/15/07
Office note, Dr. 02/15/07
Office note, Dr. 02/20/07
Office notes, Dr. 02/23/07, 03/13/07 and 05/11/07
Work status report, Dr. 02/23/07
Non-certification noted, Dr. 03/06/07
Admission record, 03/18/07
Left ankle x-ray, 03/18/07
Non-certification noted, Dr. 03/19/07
Functional capacity evaluation, 04/12/07
IRO Request Form
Notice of Assignment, 06/15/07
Office note, Dr. 02/15/07
Therapy notes 02/19/07, 02/23/07, 02/26/07, 03/02/07, 03/09/07 and 03/06/07
Prescription noted
Work Status note, 05/11/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female injured when she was pulling a patient in bed and injured her chest wall and also developed low back pain following the event. A MRI of the lumbar spine showed an L4-5 small bilateral facet effusion and minimal posterior disc bulging. There was L5-S1 disc desiccation with a moderate left and central disc protrusion minimally displacing the S1 nerve root in the canal with no significant foraminal narrowing. Minimal facet hypertrophy was noted bilaterally with mild foraminal narrowing with no foraminal root encroachment. Mild congenital narrowing was seen diffusely due to short pedicles. A 02/15/07 EMG was normal of the lower extremities.

The claimant was treated by Dr. in 2007 for ongoing low back and bilateral leg pain complaints. On examination there was tenderness and spasm. A 02/20/07 Designated Doctor's Examination with Dr. noted that on physical examination there was tenderness of the lumbar spine and the sacroiliac joint. Motor, sensory and reflexes were reported as normal. Straight leg raise was positive on the right. He disagreed with a previous physician that she had reached maximum medical improvement. He felt that she had not.

Due to ongoing pain, Dr. referred the claimant to Dr. for evaluation. On examination there was normal toe and heel walking. Motion was limited; straight leg raise negative bilaterally. X-rays showed mild to moderate L5-S1 narrowing. His impression was discogenic pain at L5-S1 and he recommended a discogram and CT for surgery.

This request was denied. Dr. who has continued to treat the claimant has filed an independent review request.

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

This is a female for whom request has been made to undergo discography of in her lumbar spine.

The Reviewer carefully reviewed the records as outlined. MRI scans of the thoracic and lumbar spine were completed in May and June of 2006 respectively. These showed mild disc desiccation in the lumbar spine and a moderate left and central disc protrusion possibly minimally displacing the S1 nerve root. Subsequently this individual underwent a series of epidural steroid injections but did not improve. Of note is the fact that she presented to Chiropractor Weeks with profound weakness in the lower extremities. Reportedly she had to use her hands to lift her legs. In spite of what would by description be consistent with lower weakness, EMGs were normal. Subsequently she developed new pain described as abdominal and leg pain as well as chest wall pain. No firm diagnosis was made to explain those pain complaints. She later presented with a combination of back and leg pain for which discography was recommended. On two occasions, discography has been determined to be not medically necessary.

There is no compelling indication that the claimant is a surgical candidate. As such, the Reviewer cannot recommend the proposed discography as being reasonable or medically necessary. Discography in itself has limited diagnostic value. In an individual whose pain complaints appear to be largely subjective and at the very least unreasonable based on the description of objective findings, then the Reviewer would submit that there is little clinical value to be obtained by proceeding with this test. There is certainly no indication of instability or neurologic deficit that would suggest that this particular study is likely to guide treatment and as such the Reviewer would support the previous reviewer's denial of the services being reasonable and 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

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back-Discogram

- 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)