

# C-IRO, Inc.

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

**DATE OF REVIEW:**  
JUNE 25, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Cervical discogram with possible post CT

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

Board Certified

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> 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**

Designated doctor exam, Dr., 07/31/06  
RME, Dr., 08/01/06  
Prescription for discogram, Dr., 09/18/06  
Claims submitted for review, 09/25/06  
Letter, Dr., 10/24/06  
Carrier Correspondence

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a delivery driver who was in a motor vehicle accident on xx/xx/xx. On xx/xx/xx, Dr. performed a designated doctor examination and documented that the Patient had been treated with Robaxin, transcutaneous electrical nerve stimulation and massage. Exam findings revealed tenderness, spasm and a negative cervical foraminal compression test but cervical spine range of motion was decreased. There were no neurologic deficits. Dr. documented that the 03/08/06 MRI of the cervical spine showed mild endplate osseous, facet degenerative changes and a broad based left paracentral disc protrusion at C5-6.

Dr. impression was that the pain reported seemed to correlate more with the discogenic pain than with the nerve root pain. Dr. did not feel the Patient was at maximum medical improvement and a discogram was recommended to obtain more information about the producing disc on the MRI.

On 08/01/06, Dr. performed a required medical examination. Dr. reading of the 03/08/06 cervical MRI was that it was normal. Exam findings revealed limitations in cervical range of motion and intact motor, sensory and reflexes. Diagnosis was cervical strain with chronic neck pain. Dr. did not feel that a discogram or cervical injections were indicated. Dr. opined that no additional treatment was medically necessary. Dr. placed the Patient at permanent and stationary. The 09/25/06 cervical discogram showed a high grade right and left posterior annular tear present. There was a 2 millimeter posterior protrusion mildly indenting the sac. No central stenosis or remarkable foraminal narrowing was noted. A C5-6 broad based annular tear was present. A 2.5 millimeter left posterior protrusion moderately indented the sac and mildly narrowed the left foramen.

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

Based on the information reviewed, there was no medical necessity for the cervical discogram. This Patient reportedly has degenerative changes on the 03/08/06 MRI and a protrusion at C5-6. On xx/xx/xx, Dr. noted that the Patient's pain correlated more with discogenic pain than nerve root pain. There were no neurologic deficits documented in the examination by Dr. or by Dr. who performed a required medical examination on 08/01/06. Dr. recommended a discogram and post CT. The 09/25/06 Discogram and post CT scan showed an annular tear at C5-6 with a 2.5 millimeter left posterior protrusion indenting the sac and mildly narrowing the left foramen. Prior to the discogram, the Patient did not appear to be a surgical candidate given the lack of any neurologic findings and that has not changed since the discogram was performed. There is significant scientific evidence that questions the usefulness of discography. Clear evidence is lacking to support its efficacy over other imaging procedures in identifying the location of cervical symptoms, and, therefore, the discogram is not recommended as medically necessary retrospectively.

**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, Neck and upper Back, Acute and Chronic

- 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)**