

October 8, 2007

REVIEWER'S REPORT

DATE OF REVIEW: 10/06/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar discogram with CT scan follow through.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., Board Certification: American Board of Orthopedic Surgery, with extensive experience in the evaluation and treatment of injured employees.

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. TDI Case Assignment
2. Carrier's Letters of Denial dated 01/03/07 and 01/15/07, referencing publications Caragee, et al, Spine J. 2002 Jan-Feb and Spine 2000 Dec as review criteria
3. Evaluations dated 05/15/06 and 05/16/06
4. Letters of medical necessity dated 01/08/07 and 01/17/07
5. MRI reports dated 07/18/06 and 06/27/07
6. Neurological surgery consultations dated 09/18/06 and follow ups on 11/08/06 and 12/13/06
7. Epidural steroid injections dated 10/04/06 with 10/12/06 phone consultation, and 11/22/06
8. Physician progress notes dated 05/24/06 through 03/05/07 (eighteen visits)
9. Review of medical history and physical examination dated 12/13/06 through 07/20/07 (4 visits)
10. Functional Capacity Evaluation dated 02/27/07

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This xx-year-old female suffered a physical exertion straining-type injury on xx/xx/xx. The injury resulted in chronic low back pain. She has undergone epidural steroid injections that have been of some benefit, though not long-lasting.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

Discogram is a controversial study. Some suggest it can be beneficial in determining sites of pain generation and could be beneficial if spine fusion is contemplated. At the present time, I see no indication that lumbar fusion is being contemplated. There is no indication of compression neuropathy, which would require a decompression surgical procedure.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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, Low Back Chapter, pages 1008-1009.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)