



# PROFESSIONAL ASSOCIATES

## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WCN

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**DATE OF REVIEW:** 04/07/08

**IRO CASE #:**

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

Lumbar discogram with post discogram CT scan at L3-L4, L4-L5, and L5-S1

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

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.

Lumbar discogram with post discogram CT scan at L3-L4, L4-L5, and L5-S1 - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

MRIs of the lumbar spine and thoracic spine interpreted by  
, D.O. dated 09/06/06

An evaluation with, D.O. dated 08/30/07

An EMG/NCV study interpreted by, M.D. dated 09/18/07

Evaluations with, M.D. dated 10/18/07 and 01/17/08

Request for reconsideration notes from Dr. dated 11/13/07 and 02/06/08

A prescription from Dr. dated 01/18/08

A letter of non-certification, according to the ODG, from, M.D. dated 01/25/08

Letters of non-certification, according to the ODG, from M.D. dated 03/07/08 and 03/14/08

The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

MRIs of the lumbar and thoracic spine interpreted by Dr. on 09/06/06 revealed very minimal disc bulges at C5-C6 and C6-C7. On 08/30/07, Dr. recommended an orthopedic consultation, injections, and an EMG/NCV study of the lower extremities. An EMG/NCV study interpreted by Dr. on 09/18/07 revealed a bilateral L5 radiculopathy. On 11/13/07, Dr. provided a reconsideration request for epidural steroid injections (ESIs). On 02/06/08, Dr. provided a reconsideration request for a discogram. On 01/25/08, Dr. wrote a letter of non-certification, according to the ODG, for a lumbar discogram. On 03/07/08 and 03/14/08, Dr. wrote letters of non-certification, according to the ODG, for a lumbar discogram.

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

The patient does not have any evidence of any positive findings on the MRI. Dr. indicated on 09/06/06 that the disc spaces were normal with no evidence of bulging, rupture, or protrusion. In the absence of any positive findings on an MRI, a discogram is not reasonable or necessary.

The ODG does not consider that discography is reasonable or necessary due to the large number of false/positive evaluations. It is not useful as an evaluation for pre-surgical treatment, including IDET or fusions. Therefore, the requested lumbar discogram with post discogram CT scan at L3-L4, L4-L5, and L5-S1 is neither reasonable nor 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)