

## Notice of Independent Review Decision

DATE OF REVIEW: 08/25/08

IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar discogram @ L2-S1, Lumbar CT scan @ L2-S1

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

It is determined that the lumbar discogram @ L2-S1, Lumbar CT scan @ L2-S1 is not medically necessary to treat this patient's condition.

### 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

- Information for review by an IRO – 08/13/08
- Decision letter– 07/29/08, 08/07/08
- Mental health evaluation – 07-09-08
- Chart Notes from Dr. – 01/28/08 to 08/07/08
- Operative Report for Laminectomy & Discectomy – 12/04/07

- Notice to URA of assignment of IRO – 08/14/08
- Pre-Surgical Psychological Testing – 08/31/07
- Request for work hardening program – 04/03/08
- Intermediate functional capacity evaluation – 03/13/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was moving a heavy appliance and the cart went off of the loading ramp throwing him against another box injuring his low back and right leg. The patient complains of a constant sharp, stabbing, and gnawing sensation that rates 9 out of 10. The patient reports that he is unable to sit, walk or stand for long periods of time due to the pain he experiences in his lower back, accompanied by numbness and tingling in his lower extremities. The patient has a history of undergoing laminectomies, foraminectomies, and discectomies at multiple levels.

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

The ODG 2008, Low Back Chapter relates to the performance of discography. This study is controversial in that the results are not considered reliable. False positive studies are reported as unreasonably high. It is not considered a sensitive study and false negatives, especially for radiculopathy are reportedly high. Therefore, it is determined that the lumbar discogram @ L2-S1, Lumbar CT scan @ L2-S1 are 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)