

**NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION**  
*Workers' Compensation Health Care Non-network (WC)*

**DATE OF REVIEW: 08/18/2008**

**IRO CASE #:**

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

L3-4, L4-5, L5-S1 discogram with post CT scan

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

**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**

1. Texas Dept of Insurance Assignment to 7/29/2008
2. Confirmation of Receipt of a Request for a Review by an IRO 7/28/2008
3. Company Request for IRO Sections 1-8 undated
4. Request For a Review by an IRO patient request 7/24/2008
5. reconsideration letter 07/17/2008
6. request for certification undated
7. note 07/22/2008, 07/21/2008, 07/09/2008, 07/02/2008, 06/11/2008, 03/03/2008, 02/12/2008, 01/03/2008, 11/29/2007, 08/28/2007, 08/14/2007, 08/06/2007 (MRI), 07/03/2007
8. ODG Guidelines were not provided by the URA.

**PATIENT CLINICAL HISTORY:**

This is a xx-year-old male who sustained a work-related injury on xx/xx/xx. Claimant was pulling a pallet jack when the jack became stuck on an uneven surface. Claimant attempted to pull the pallet jack up over the uneven surface causing pain and discomfort in his low back. Subsequent to the injury, claimant underwent conservative treatment consistent with physical therapy and medication management. The patient complained initially of low back pain with radiation to the lower extremities. The patient completed conservative treatment consisting of physical therapy and medication management. A lumbar MRI performed on 08/06/07 was read as normal. Following this, reportedly, claimant underwent myofascial trigger point injections as well as lumbar epidural steroid injections without relief. Clinical examination reveals positive straight leg raise with diminished sensation and diminished strength at L4-5 and L5-S1 levels. Patient's current diagnoses are: Low back pain syndrome; Lumbar radiculopathy; Chronic intractable pain syndrome. The treating physician is requesting a lumbar discogram as an objective test to delineate the levels in the lumbar spine that are causing this patient's symptomology.

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

After reviewing the information submitted, the previous nonauthorization for the above-requested intervention has been upheld. The treating physician has not determined medical necessity. The submitted lumbar MRI report dated 08/06/07 was read as normal with no evidence of significant disk bulge or herniation at any level, no spinal canal stenosis or foraminal stenosis. There was normal vertebral body alignment without spondylolisthesis.

According to the Official Disability Guidelines, this procedure is not recommended. In the past, discography has been used as part of the preoperative evaluation of patient for consideration of surgical intervention for low back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints or injection of one or more disks (concordance of symptoms) is of limited diagnostic value. Currently, with the lack of lumbar MRI findings, there does not appear to be any valid objective reason for this claimant's ongoing pain complaints.

Submitted documentation does not support the indication for further consideration of invasive treatment or pre surgical diagnostic evaluation such as discography. Guidelines and References used: Official Disability Guidelines, Treatment Index, Fifth Edition 2008 (web) under Low Back, Discography.

**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)**