



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 7/15/08

**IRO CASE #:**

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

The services under dispute include a low pressure lumbar discogram with post discogram CT scan.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery and who has greater than 15 years of experience.

**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)

The reviewer agrees with the previous adverse determination regarding all services under review.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Dr. and from Insurance.

These records consist of the following (duplicate records are only listed from one source): Dr.: 9/5/07 through 2/14/08 CMT and ROM tests, Thoracic MRI of 11/2/07, BHI report 2/21/08, FCE 11/14/07, lumbar radiographic report by Dr. (undated), lumbar MRI 4/10/07, denial letter 5/16/08 and 5/27/08, AAOS CH 16 pgs 81-84, 143 to 144, medical board bulletin regarding MD, 6/13/08 LMN, 3/5/08 psych eval, 9/5/07 through 5/6/08 reports by Dr., 4/4/08 IRO report, 3/5/08 peer review, 4/2/08 letter by Dr. and DWC 69 and report of 10/27/07.

: Dr Procedure order (preauth request) 5/13/08, 7/17/07 to 10/23/07 operative reports and 1/10/08 PLN 11.

We did not receive an ODG Guideline from the Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a xx year old male who injured his back lifting rolls of vinyl on xx/xx/xx. An MRI of his lumbar spine 04/10/07 read as having 1mm bulges at L2/3 (with partial desiccation noted), L4/5, and L5/S1 without significant canal or foraminal stenosis by Dr.. Patient was treated with chiropractic care and physical therapy, was seen by a designated doctor and placed at MMI with 5% Impairment on 10/27/07. Mr. underwent psychological eval on 2/21/08 (BH12) that revealed anxiety, depression and somatization, unrealistic expectations of being pain free. Psychiatric evaluation by Dr resulted in diagnosing Mr. with pain disorders related to psychological factors (ICD 307.89, mild). Dr note of 5/06/08 notes 4/10 pain, on 12/19/07 pain was stated as 3/10. Request has been made to determine the prospective medical necessity for discography and post discography CT.

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

While not recommended above, if a decision is made to use discography anyway, the following criteria should apply:

- o Back pain of at least 3 months duration
- o Failure of recommended conservative treatment including active physical therapy
- o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)
- o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided)
- o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive. NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria.
- o Briefed on potential risks and benefits from discography and surgery
- o Single level testing (with control)
- o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification.

Because this patient does not meet all of the above requirements, this procedure is not certified as medically necessary. Therefore, the request is denied for certification.

**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)