



Notice of Independent Review Decision

**DATE OF REVIEW: 7/24/08**

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for a lumbar discogram at L2-3, L3-4, L4-5 and L5-S1.

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

Texas licensed Orthopedic Surgeon.

**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.

The previously denied request for a lumbar discogram at L2-3, L3-4, L4-5 and L5-S1.

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

- Fax Cover Sheet dated 7/21/08.
- Notice of Assignment of Independent Review Organization dated 7/21/08.
- Notice to CompPartners, Inc. of Case Assignment dated 7/21/08.
- Cover Letter dated 7/21/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/18/08.
- Request Form Request for a Review by an Independent Review Organization dated 7/18/08, 7/16/08.
- Company Request for Independent Review Organization dated 7/18/08.
- Fax Cover Sheet/Authorization Request dated 7/17/08.
- Adverse Determination After Reconsideration Notice dated 7/10/08.
- Exam Note dated 6/26/08.
- Adverse Determination Notice dated 6/23/08.
- Report of Medical Evaluation dated 6/9/08.
- Required Medical Evaluation Report dated 6/9/08.
- Evaluation/Interview Report dated 5/16/08.
- Re-Evaluation Report/Letter dated 4/21/08.
- Recommended Services for Medical Treatment dated 4/21/08.
- Doctor's First Report of Occupational Injury or Illness dated 4/4/08.
- Cervical Spine CT Scan Report dated 3/27/08.
- Lumbar Spine CT Scan Report dated 3/27/08, 9/21/07.
- Physical Therapy (Re-Evaluation)/Plan of Care Note dated 1/23/08, 12/27/07, 11/2/07, 10/9/07.
- Initial Evaluation Report dated 11/12/07.
- Lumbosacral X-Ray dated 9/21/07.
- Injured Worker Information Sheet (unspecified date).

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx years

**Gender:** Male

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Fell while carrying equipment weighing 100 pounds.

**Diagnosis:** Cervical and lumbar strains and lumbar spondylosis.

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

The claimant is a xx-year-old male employed as a at the time of his reported injury onxx/xx/xx. He reportedly fell while carrying equipment weighting 100 pounds, striking his posterior neck and lower back. His medical history was positive for a previous lumbar laminectomy 17 years ago and chronic atrial fibrillation with pacemaker implant. He began treatment for complaints of neck and low back pain. Lumbar X-rays on 09/21/07, noted spondylosis at L4-5 and L5-S1. A lumbar CT on 09/22/07, revealed a mild disc bulge at L3-4 and diffuse disc bulges at L4-5 and L5- S1, with mild canal and bilateral neuroforaminal stenosis. Treatment included therapy and one epidural steroid injection, with no significant benefit. On 03/27/08, a lumbar myelogram and post CT scan noted markedly reduced L4-5 disc space with disc bulge, endplate changes, osteophytes and facet hypertrophy. There was mild spinal canal and moderate neuroforaminal narrowing bilaterally at L4-5 that may affect the exiting nerve roots. There was minimal retrolisthesis of L5 over S1. An L4 laminectomy defect was noted. Disc space at L5-S1 was mildly reduced with a broad based disc bulge, endplate changes, osteophytes and facet hypertrophy producing mild spinal canal narrowing. There was a mild disc bulge at L3-4 noted. Electrodiagnostic studies of both lower extremities on 04/04/08 were normal. Dr. saw the claimant on 04/21/08, and felt the claimant had mechanical back and neck pain unresponsive to several months of conservative care and recommended cervical and lumbar discography to determine if surgery was indicated. Dr. preformed an Independent Medical Evaluation and Impairment Rating on 06/09/08. Examination noted decreased lumbar motion with lower midline tenderness. Ankle jerks were absent bilaterally and supine straight leg raise on the left produced low back pain radiating to the posterior thigh at 30 degrees and low back pain at 45 degrees on the right. The impression was chronic pain syndrome with degenerative changes in the lumbar spine and non-verified radiculopathy in the left lower extremity. The request for lumbar discogram was non-certified in a previous review. The request was submitted again for review. As outlined in the ODG, discography is in general, not recommended. The conclusions of recent high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for procedures including spinal fusion. It is certainly not clear that this patient would be a candidate for fusion in any case. Based on the information available, this reviewer would not recommend the proposed discography as 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 AND 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.
- X** ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES. Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low Back: Discography. Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower 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.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).