

# Independent Resolutions Inc.

An Independent Review Organization

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**DATE OF REVIEW:** March 3, 2008

**IRO CASE #:**

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

Lumbar discogram with CT scan

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

Board Certified 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Office note, Clinic, 04/21/07, 06/21/07

MRI thoracic, 05/18/07

MRI lumbar, 06/18/07

Office note, Dr. 06/11/07

X-ray lumbar, 06/26/07

EMG/NCS, 07/20/07

Pain management request, 11/30/07

Office note, Dr. 01/04/08

Letter of Medical Necessity, Dr. 01/18/08

Pre authorization request for lumbar discogram, 01/14/08, 02/11/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

HEALTH AND WC NETWORK CERTIFICATION & QA 3/24/2008

IRO Decision/Report Template- WC

This female claimant reportedly sustained a low back injury while attempting to lift a patient. The records indicated that the claimant reported an immediate onset of acute low back pain with intermittent pain into both lower extremities. An evaluation on 06/11/07 indicated that the claimant continued with back pain worse with sitting, standing, coughing or sneezing. A lumbar MRI on 05/18/07 showed a herniated nucleus pulposus at L5- S1 with bilateral effacement of the S1 nerve root and right sided foraminal stenosis along with decreased disc height and disc desiccation at L5- S1. A lumbar x-ray showed wide based foraminal stenosis. The claimant was diagnosed with lumbar disc displacement, lumbar radiculitis, lumbar degenerative disc disease and lumbago. A CT discogram was recommended to better evaluate internal disc disruption as a pain generator. Lumbar x-rays showed scoliosis and L4-5 and L5- S1 disc space narrowing. An EMG/NCS was also recommended that was done on 07/20/07 and showed no conclusive evidence of a right or left acute lumbosacral radiculopathy. A lumbar discogram has been requested.

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

The claimant is a female who reportedly injured her low back for whom the request has been made to perform lumbar CT discogram.

There is no compelling indication to recommend CT discography in this individual's case. Reportedly she has a disc herniation towards the right at L5-S1 with complaints of right lower extremity pain, a positive straight leg raise, and diminished ankle jerk. It is unclear as to why CT discography would be the next step in terms of treatment as this would not be a typical test to treat someone's symptomatic disc herniation. There is no discussion within the records as to why CT discography would be the treatment of choice for an individual who reportedly suffers from a symptomatic disc herniation. Furthermore, after a careful review of all medical records it is unclear to the Reviewer as to how she responded to epidural steroid injections in the past or as to what particular information was going to be gleaned from the CT discography that would help further her treatment plan.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, 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)**