

Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 9, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Discogram w/Post CT Scan

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

MD, 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)

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 reviewer finds that medical necessity does not exist for Lumbar Discogram w/Post CT Scan.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year-old male with discogenic low back pain. The MRI of the lumbar spine from 11/28/07 showed a severely limited examination secondary due to motion artifact, disc desiccation at L4-5 with a mild diffuse annular protrusion which was slightly eccentric to the left posterolaterally and no evidence of severe central spinal canal stenosis. The 05/07/08 behavioral medical evaluation deemed the claimant a good candidate for surgery with provisions. The designated doctor's evaluation on 06/20/08 recommended additional diagnostic testing. Dr. performed a designated doctor's examination and noted positive Waddell signs. The most recent exam on 08/07/08 documented no radiculopathy.

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

The requested lumbar discogram with post discogram CT is not medically necessary based on review of this medical record. This claimant was injured in xx/xxxx and continues to have back and leg pain. He has undergone a lumbar MRI documenting degenerative disc change without clear evidence of nerve root abnormality, severe spinal stenosis, or disc herniation. This MRI shows eccentric disc changes to the left, but the claimant has undergone a previous EMG documenting some right L6 radiculopathy. There are also multiple unusual areas of documentation in the medical record to include a 06/20/08 office visit of Dr. that documents a negative straight leg raise, yet weakness of the right hip, ankle, and great toe, which would obviously encompass multiple disc levels and multiple nerve root levels, which is a nonanatomic finding. There was also a 08/07/08 office visit of Dr. that documents no evidence of radiculopathy, and every category of Waddell sign is positive.

Official Disability Guidelines indicate that discogram is not recommended, and that it is a very subjective test without good objective correlation. In light of the fact that this claimant has significant Waddell signs and has nonanatomic findings, and there is no clear documentation of a disc herniation or true abnormality, then this requested discogram is not medically necessary. The reviewer finds that medical necessity does not exist for Lumbar Discogram w/Post CT Scan.

Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, low back-discogram 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. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) is of limited diagnostic value.

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) (Carragee, 2006) 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) (Colorado, 2001)
- o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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)