RyCo MedReview
514 N. Locust
Denton, TX. 76201
Off: (940) 239.9049
Fax: (940) 239.0562

Notice of Independent Review Decision

DATE OF REVIEW: 09/02/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Discography
Radiological Supervision and Interpretation

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

Licensed in Physical Medicine & Rehabilitation

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.

Lumbar Discography - Upheld
Radiological Supervision and Interpretation - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Examination evaluation, M.D., 01/17/08, 06/17/08, 07/15/08

- Pre-Authorization, D.O., 07/01/08
- Letter regarding adverse determination, 07/01/08, 07/15/08, 07/18/08
- First Level Dispute Resolution Request for Review, Dr. 07/15/08
- Appeal letter, M.D., 07/17/08
- Two letters regarding Pre-Authorization, (no date)
- Notice to URA of Assignment of IRO, 08/11/08
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained an injury to his lower back and was diagnosed with lumbar discogenic pain at L3-S1. He underwent an MRI in December of 2006 which revealed evidence for "bulges again at L2-L3, L3-L4, and L4-L5". In June of 2008 it was recommended that an electrodiagnostic assessment of the lower extremities be accomplished and that a discogram be obtained. In July of 2008 it was recommended that consideration be given for an upright lumbar MRI study.

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

With respect to the above noted questions, ***Official Disability Guidelines*** do not support a medical necessity for lumbar discogram for the described medical situation. In this case, it would appear that a lumbar MRI accomplished in December of 2006 revealed evidence for disc degenerative changes in at least three levels in the lumbar spine. The described findings on the lumbar MRI would typically be considered a relative contraindication for pursuit of a lumbar discogram. Additionally, prior to consideration of a lumbar discogram, there must be evidence of a detailed psychological assessment to determine if any barriers to recovery with respect to symptoms of low back pain. The above noted reference does note that "due to high rates of positive discograms after surgery, lumbar disc herniation, this should be a potential reason for noncertification". Hence, based upon the medical records available for review, in the described medical situation, there would not appear to be a medical necessity for a lumbar discogram. Given the fact that there appears to be multiple levels of pathology, multiple references in the medical literature would question the benefit of any potential invasive procedure to the lumbar region. Consequently, there would not appear to be a medical necessity for a lumbar discogram.

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)**