

SENT VIA EMAIL OR FAX ON  
Jun/17/2009

## P-IRO Inc.

An Independent Review Organization  
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**DATE OF REVIEW:**

Jun/12/2009

**IRO CASE #:**

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

L4/S1 CT Discogram

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC SURGERY

**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

Denial Letters 4/28/09 and 4/6/09

Dr. 4/1/08 thru 5/22/09

Occupational Medicine 1/6/09 thru 3/24/09

MRI 1/26/09

X-Ray 11/25/08

Brain & Spine 1/29/09

CT Pelvis 12/14/07

Dr. 8/27/08

Spine & Ortho 7/14/09 thru 11/12/09

Radiology 9/27/08

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man involved in accident on xx-xx-xx. A large piece of metal perforated his rectum and fractured his sacrum and coccyx. He has ongoing left lower extremity pain that was felt to be in a left L5/S1 distribution. His EMG reportedly showed a left L4/5 radiculopathy. The study was not provided. An MRI in January 2008 showed multiple degenerative levels of the discs, and retrolithesis at L2/3. A repeat MRI on 1/26/09 showed disc bulges at L2/3 and L4/5 with central lumbar stenosis at these levels. A CT of the pelvis in December 2008 showed a

left sacral ala fracture that was healing and had scar tissue on the S4 and S5 nerve roots. A discogram by Dr. in August 2008 showed concordant pain at L2/3 and L4/5, but not at other levels. Plans for a 360 fusion were apparently denied as well as requests for prior CT Discograms. This man had no response to epidural injections at L4/5 and L5/S1. The most recent examination showed some reduced left quadriceps strength on muscle testing, but symmetrical reflexes.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The ODG generally does not support the role of a discogram. Prior false positive studies have been attributed to the ionic nature of the dye use. More recent studies show that there are psychological factors present. In fact, a negative discogram is more significant than a positive one. Yet this man had a prior discogram without a CT scan that showed concordant pain. The ODG states that Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion (but a positive discogram in itself would not allow fusion). This in itself is a problem here in that the surgeon is considering the fusion, but denied by the insurance company. Using this logic, the procedure cannot be approved if there is not going to be a fusion. Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. The ODG also has criteria to follow if the surgeon and the insurance company approve the procedure. Obviously this review shows the difference of opinions for the study.

Dr. challenges the prior reviewer's decisions as being based upon the ODG and not based upon his and the neurosurgeon's experience. The ODG is reportedly based upon evidence-based medicine and therefore does not rely on individual's personal experiences. Therefore, different specialists who are involved in the care of patients can utilize these Guidelines to reach a decision for appropriate care. Variance is allowed provided there is justification. This man already had a discogram. The American Society of Interventional Pain Physicians established their own guideline. It reads "The evidence for lumbar discography is strong for management of discogenic pain provided it is performed based on patient history, physical examination, imaging data, and analysis of other precision diagnostic techniques."

This would pose a conflict comparing the two evidence-based guidelines. However, the Texas Workers' Compensation Division recommends the ODG and gives it more credence.

Dr. noted that there was evidence of instability at L2/3, but the discogram is for the L4/5 and L5/S1 levels. This person had a prior positive provocative discogram. The criterion for instability is established by the AMA Guides.

"Lumbar fusion in workers' comp patients." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy. [For spinal instability criteria, see AMA Guides (Andersson, 2000)]

Therefore without approval for fusion based upon the criteria in the ODG, there is little justification for the discogram. The discogram can only be justified if the fusion was approved pending the results of the discogram. The Reviewer role is not to approve or disapprove the fusion, but only the discogram. With these criteria, the Reviewer cannot approve the CT-discogram.

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

[ ] ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**