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Notice of Independent Review Decision

DATE OF REVIEW: October 6, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar discogram with post CT scan to include CPT code #62290, 72295, 72131.

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

Diplomate, American Board of Orthopedic 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

Medical records from the Requestor/Provider include:

PATIENT CLINICAL HISTORY:

The request is for a lumbar discogram followed by a CT scan from M.D.

The patient is a male who was pulling a cable off the ground when he felt his back pop with intermittent pain. He did not complain of radicular pain initially. The past history

reveals he sustained a work-related back injury xx years ago from which he continues to have intermittent pain that he controls with over the counter medications.

Dr. reads an L4-5 disc bulge as a right-sided herniated disc, however, the patient's complaints are almost entirely on the left side, including a decreased left ATJ (which would relate to the L5-S1 level, not the L4-5) and an "exquisitely positive left straight leg raise." He also documented at first right anterolateral leg numbness and later right lateral thigh numbness, which does not describe an L5 dermatome. Sometimes, he also documents the left posterior thigh numbness, which again would not relate to an L5 dermatome, however, rather to an S1 dermatome. More importantly, however, is the lack of image support for a disc herniation. The MRI report clearly indicates that there is a small L4-5 disc bulge and a small central L5-S1 disc protrusion, without neural involvement.

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

In sum, there is no support for a disc herniation and no support for a surgical procedure. A discography is and continues to be a controversial diagnostic tool. It is not indicated or recommended in patients with chronic pain, such as in this case or on patients with depression and psychosocial problems, because of the high rate of false positive findings (ODG, Back Chapter, 2008 and ACOEM, Chapter 12, 2nd Edition, 2004). For this reason, pre-discography psychological screening is indicated to include psychometric testing and MMPI-2 testing (ODG, Back Chapter and ACOEM, 2nd Edition, 2004). Additionally, when a discography is accepted as a diagnostic tool (rarely), it is in the

context of a patient that has been determined to have a fusion, and its use is confined to the evaluation of the condition of an adjacent suspicious disc. A discography is not to be used as a standalone diagnostic tool upon which a fusion procedure would be performed (ODG, Back Chapter) and (NASS Contemporary Concepts and Spine Care, 2001) and (Carnegie, Spine, 2000). The ODG also does not recommend a discography. Therefore, based on the above rationale and peer reviewed guidelines and the spine literature, the request for discography followed by a CT scan is noncertified.

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)**