

SENT VIA EMAIL OR FAX ON  
Aug/09/2010

## Pure Resolutions Inc.

An Independent Review Organization  
1124 N Fielder Rd, #179  
Arlington, TX 76012  
Phone: (817) 349-6420  
Fax: (512) 597-0650  
Email: manager@pureresolutions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/05/2010

**IRO CASE #:**

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

L3/4, L4/5, L5/S1 Lumbar Discogram

**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 notes, Dr., 12/18/08, 01/22/09, 02/25/09, 04/01/09, 05/14/09, 06/16/09, 07/28/09, 12/01/09, 02/05/10, 05/26/10

Electrodiagnostic Study, 01/15/09

MRI lumbar spine, 01/15/09

Bilateral L4-5 and L5-S1 facet joint block, 02/13/09

Consult, Dr., 03/06/09

Office notes, Dr., 08/13/09, 03/05/10, 04/30/10

Denial, Dr., 10/12/09

Consult, Dr., 04/19/010

FCE, 04/21/10

Office note, Block, PhD, 05/26/10

Peer Review, 06/11/10, 06/28/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who sustained a work related injury to his low back on xx/xx/xx. The mechanism of injury was lifting. The claimant has been treated with extensive chiropractic decompression, which only helped temporarily, some physical therapy, stretching and bilateral facet injections at L4-5 and L5-S1 (02/13/09) with no change in his symptoms. An MRI of his lumbar spine on 01/15/09 revealed degenerative disc disease in the lumbar spine greatest at L4-5 and L5-S1 with no central spinal stenosis or foraminal stenosis. An electrodiagnostic study on 01/15/10 was normal. AP and standing lateral flexion/extension x-rays on 03/06/09 showed no instability on flexion/extension views. A discogram was recommended in March of 2009, but because the claimant had a lot of depressive symptoms, he was not cleared for the discogram. He was put on Lexapro and a discogram was again recommended but was non-certified. In August of 2009 surgery was recommended but it

was denied because the pain generators needed to be identified. The claimant underwent a functional capacity exam on 04/21/10 and tested at a light level for work above the waist and at sedentary for work below the waist. The claimant saw Dr. on 04/30/10 and he recommended that the claimant undergo a psychological assessment, then a discogram to identify the individual disks as pain generators in anticipation of surgical intervention. The claimant was seen by Dr. for a psychological assessment on 05/26/10 and was cleared for a discogram. Dr. again recommended a discogram to see if the claimant was a surgical candidate. The request has been denied by two peer reviews.

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

The records in this case would appear to reveal only some degenerative change. The electrodiagnostics have been negative. There has been no instability. There do not appear to be ongoing neurologic findings.

If one turns to the ODG Guidelines, discography in general is not recommended. Recent literature has not suggested that discography is a reliable screening tool for surgical care. The information presented in this case would not satisfy the guidelines for medical necessity for the proposed study.

Official Disability Guidelines Treatment in Worker's Comp, 15<sup>th</sup> edition, 2010 Updates. Low Back: Discography  
Discography is Not Recommended in ODG.

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)