

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jun/23/2010

**IRO CASE #:**

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

Lumbar discogram with CT scan

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

MD, Board Certified in Neurological 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**

Adverse Determination Letters, 05/3/10, 5/19/10  
ODG "Low Back" chapter, Discography  
M.D., P.A. 5/12/10, 4/27/10  
DFW MRI 9/11/09  
Medical Imaging 2/24/10  
DTI 10/22/09  
Radiologics 9/12/09  
Back Institute 3/4/10  
M.D. 1/12/10, 11/3/09, 10/13/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with a date of injury xx/xx/xx. The claimant was injured while drilling holes. He complains of chronic low back pain and left leg pain. He has undergone 2 ESIs. His neurological examination is normal. An MRI of the lumbar spine 09/11/2009 shows a broad-based disc protrusion at L4-L5 and L5-S1 with minimal narrowing of the bilateral neuroforamina. A CT myelogram 02/24/2010 reveals at L4-L5 a 3mm broad-based right posterior disc bulge/protrusion with some thecal sac compression but no stenosis. An EMG 10/22/2009 suggests bilateral L5 radiculopathies and left S1 radiculopathy. The claimant has a history of depression.

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

Discography is "not recommended" by ODG. According to the guidelines, discography should not be used as a search for a pain generator in order to proceed with a lumbar fusion. In addition, if discography is going to be done, according to the ODG, a detailed psychological evaluation should be performed prior to discography. There is no evidence that this has been done. For these reasons, then, the reviewer finds that medical necessity does not exist for Lumbar discogram with CT scan.

## References/Guidelines

ODG "Low Back" chapter

Discography

Discography is Not Recommended in ODG

Patient selection criteria for Discography if provider & payor agree to perform anyway

- 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**

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)