



Specialty Independent Review Organization  
**Notice of Independent Review Decision**

**DATE OF REVIEW:** 9/3/2010

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a lumbar CT discogram.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a lumbar CT discogram.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Dr. and.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 12/3/09 lumbar MRI report, PT preauth requests 12/1/09 to 12/15/09, initial and follow up evals by 11/19/09 to 7/8/10, PT evals 11/20/09 to 1/13/10, PT daily notes 11/23/09 to 1/13/10, 12/3/09 approval letter, various DWC 73 forms, office notes by Pain Therapeutics 12/10/09, 12/7/09 script for consult, 12/16/09 denial letter, 3/18/10 new pt eval by Orthopaedic Associates, DD report of 4/22/10, preauth request 2/11/10, 1/12/10 neurodiagnostic report, 5/3/10 approval report, 4/29/10 precert request, 4/28/10 to 6/9/10 PM evaluations by, 4/23/10 FCE report, 1/5/10 denial letter, 1/27/10 letter by, MD, 4/8/10 report by, MD, 5/20/10 operative report, 7/13/10 script for L spine CT discogram, 6/21/10 eval by Dr., 7/19/10 denial letter, 3/18/10 letter by, RN, 12/3/09 PLN11, 1/12/10 office note by MD and 3/15/10 office note by MD.

Dr.: patient profile (all other records were duplicative)  
follow up report 8/5/10 (all other records were duplicative)

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant with back and leg pain and paresthesias has exam findings of reflexes of 1-2+, with normal motor power and sensation. The central disc herniation at L4-5 on the lumbar MRI dated 12/3/09 was noted. Failure of medications, injections, and therapy has been noted. Denial letters discussed the lack of medical necessity of discograms due to lack of reliability.

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

Recent studies have not documented the reliability of CT-discogram regarding determining the pain generator(s). Such studies have not proven medically necessary prior to surgical procedures such as decompression and/or fusion.

**ODGuidelines**

Low back (Updated 8 17 10)-Online

CT-Discogram-Discography: Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) is of limited diagnostic value. (Pain production was found to be common in non-back pain patients, pain reproduction was found to be inaccurate in many patients with chronic

**Indications for imaging -- Computed tomography:**

- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, infectious disease patient
- Evaluate pars defect not identified on plain x-rays
- Evaluate successful fusion if plain x-rays do not confirm fusion

**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)