



Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 01/12/11

**IRO CASE #:**

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

Lumbar discogram, L2 through S1, with L2/L3 control

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine problems

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

| <i>Primary Diagnosis Code</i> | <i>Service Being Denied</i> | <i>Billing Modifier</i> | <i>Type of Review</i> | <i>Units</i> | <i>Date(s) of Service</i> | <i>Amount Billed</i> | <i>Date of Injury</i> | <i>DWC Claim #</i> | <i>Upheld Overturn</i> |
|-------------------------------|-----------------------------|-------------------------|-----------------------|--------------|---------------------------|----------------------|-----------------------|--------------------|------------------------|
|                               |                             |                         | <i>Prospective</i>    |              |                           |                      |                       |                    | <i>Upheld</i>          |

**INFORMATION PROVIDED FOR REVIEW:**

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The injured worker is a xx-year-old male suffering lumbar spine and right leg pain. He has a past history of lumbar spine surgery approximately thirteen years prior to this recent evaluation. At that time he underwent two-level interbody fusion at levels L3 through L4 and L4 and L5. The most recent injury occurred xx/xx/xx. The examinee was utilizing a when he slipped and fell, suffering injury to his lumbar spine region on xx/xx/xx. He has had multiple evaluations for low back pain and right leg pain. He was recently evaluated for the persistence of low back pain and right leg pain subsequent to epidural steroid injections and selective right S1 nerve root injections. He has had persistent pain subsequent to these injections.

His physical findings have revealed positive straight leg raising on the right. There are no specific deficits of motor strength or sensory function. Lumbar discogram has been recommended from L2 through S1 utilizing the L2/L3 disc as control. This request was considered and denied, reconsidered and denied. The patient reports significant depression and suicidal ideation. He has been evaluated and is in treatment with a psychotherapist for such problems.

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

The patient's principle problem is chronic pain. He has significant psychological overlay with significant depression and suicidal ideation, which has been acknowledged. He is actively in treatment with a psychotherapist. The physical findings are limited. He has a positive straight leg raising test on the right side without specific deficits in sensory or motor function. The discogram is not a recommended study in the ODG 2011 Low Back Chapter. There is a specific warning that patients with chronic pain problems and emotional overlay issues are particularly at risk for worsening of pain after discography. It would appear that the prior denials were appropriate and should be upheld.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)