

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 14, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Lumbar discogram w/post discogram CT L3-4, L4-5 and L5-S1

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Orthopedic surgery, and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
unk	Lumbar discogram w/post discogram CT L3-4, L4-5 and L5-S1		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with the initial clinical evaluation completed by Dr.; referred the injured employee to Dr. to address the neck pain, back pain and radiating leg pain. The history of present illness indicates that epidural steroid injections had been completed to both the neck and back. There is no long-term benefit. Additionally, physical therapy had been completed. The pain is noted into the low back and both lower extremities and occurs all day. The physical examination noted some decreased range of motion and slightly decreased quadriceps reflexes bilaterally. The MRI noted a spondylolisthesis of 6.8 mm and a disc desiccation at L4/5 and L5/S1. Lumbar discogram was suggested. This was based on a reported spondylolisthetic instability.

The MRI report was reviewed. Noting the anterior listhesis and disc desiccation. A pre-surgical psychiatric evaluation was completed and from a psychiatric perspective, the surgical intervention was endorsed.

Subsequent to this evaluation, the request for discography was not certified. Additionally, at reconsideration, this was not endorsed.

In November, chiropractic care was delivered.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines discography is "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 patient's, pain reproduction was found to be inaccurate in many patients with chronic back pain and abnormal psychosocial testing, and in this latter patient type, the test itself was sometimes found to produce significant symptoms in non-back pain controls more than a year after testing.) Also, the findings of discography have not been shown to consistently correlate well with the finding of a High Intensity Zone (HIZ) on MRI. Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion (but a positive discogram in itself would not allow fusion). ([Carragee-Spine, 2000](#)) ([Carragee2-Spine, 2000](#)) ([Carragee3-Spine, 2000](#)) ([Carragee4-](#)

[Spine, 2000](#)) ([Bigos, 1999](#)) ([ACR, 2000](#)) ([Resnick, 2002](#)) ([Madan, 2002](#)) ([Carragee-Spine, 2004](#)) ([Carragee2, 2004](#)) ([Maghout-Juratli, 2006](#)) ([Pneumaticos, 2006](#)) ([Airaksinen, 2006](#)) ([Manchikanti, 2009](#))”

Accordingly, the determination made by prior reviewers is upheld.

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)