



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 1/5/11

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a lumbar discogram (62290).

**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 prospective medical necessity of a lumbar discogram (62290).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is status post right-sided discectomy at L5-S1. Most recently, the claimant has had back pain with bilateral leg radiation and calf cramping secondary to moving a couch while working. An MRI from 2/3/10 demonstrated an annular tear and bulge at L4-5 with enhancing scar at L5-S1. Non dermatomal decreased leg sensation has been noted. 4+ right quadriceps strength was noted. Positive SLR right > left was noted. On 11/2/10, the claimant has been noted to be more symptomatic overall. A repeat MRI was felt indicated. A 9/21/09 dated electrical study noted a right S1 radiculopathy. There was no evidence of a psychosocial screen or notation that surgical intervention was being considered. Denial letters regarding a discogram were noted. The claimant has been treated with medications, ESIs and PT.

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

The ODG states 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 patients; 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.

With there having not been a psychosocial screen prior to consideration of an invasive discogram, the procedure is not medically reasonably required. In addition, recent studies have noted that the test is not a reliable and/or consistent indicator of the pain generator(s). Therefore, the procedure is not medically necessary at this time, based on applicable clinical guidelines that were correlated with the facts in this specific case.

**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)