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Notice of Independent Review Decision

**DATE OF REVIEW:** December 20, 2010

**IRO CASE #:**

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

Lumbar Discogram: post CT Scan.

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

DIPLOMATE, AMERICAN BOARD OF ANESTHESIOLOGY  
DIPLOMATE, AMERICAN ACADEMY OF PAIN MANAGEMENT

**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**

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- Texas Department of Insurance 12/06/10
- Imaging, 05/07/10
- D.O., 06/23/10, 07/21/10, 08/18/10, 09/15/10
- Workers Compensation Pre-Cert Request, 10/15/10
- 10/21/10, 11/01/10
- Pain Management, P.A., 10/27/10
- Request for a Review by an Independent Review Organization, 12/04/10

Medical records from the Provider include:

- D.O., 09/10/09, 09/10/09
- Pain Management, P.A., 06/14/10
- D.O., 07/21/10, 08/18/10, 09/15/10, 10/13/10, 11/10/10

**PATIENT CLINICAL HISTORY:**

Of note, progress notes submitted begin in May 2010. The patient is a male who sustained a work related injury on xx/xx/xx. The mechanism of injury is not documented. Current diagnosis is cervical post laminectomy syndrome and lumbar radiculopathy. Submitted lumbar MRI report for review dated May 7, 2010, reveals lumbar spondylosis worse at L5-S1 level where there is another bilateral neural foraminal stenosis noted. No central canal stenosis or vertebral compression fracture noted. There is some edema within the interspinous ligaments at L2-3 and L3-4 suggesting the possibility of ligamentous injury. The last follow-up note submitted by the requesting provider dated October 15, 2010, indicated the patient was doing very well with the current medication. Clinical examination of the lumbar spine revealed, paraspinal muscle tenderness bilaterally, lower extremities intact. Neurological evaluation was intact of the lower extremities.

With regards to the IRO request, there was no additional comprehensive information documenting the efficacy and medical necessity of the proposed treatment submitted.

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

After review of the information, preceding the previous non-authorization request for lumbar discogram with post disco CT scan has been upheld in accordance with ODG Guidelines, Treatment and Treatment Index 8<sup>th</sup> Edition (Web), 2010 under Low Back/Discography. These guidelines do not recommend discography. Recent high quality studies have significantly questioned the use of discography results as a pre-operative indication for either IDET or spinal fusion. Additionally, criteria indications indicate back pain of at least three months duration, failure of recommending conservative treatment to include interventional pain management injections, lumbar MRI demonstrating one or more degenerative discs as well as one or more normal appearing discs to allow for internal control injection (injection of normal disc to validate the procedure by lack of pain response to that injection), satisfactory results from detailed psychosocial assessment; intended as a screen for surgery. With the lack of information as stated above, the previous denials for the recommended procedures 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
- 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)