

# Wren Systems

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/23/2011

**IRO CASE #:**

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

Lumbar Discogram at L2-L3, L5-S1 with Control level of L4-L5 followed by CT

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

M.D. – Board Certified Orthopedic Surgeon

**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**

CT Report: 08/04/10

MRI Report: 08/04/10

Dr.: 04/13/10, 08/10/10, 03/08/11

Dr.: 09/27/10, 12/08/10, 03/01/11, 03/14/11

Peer Review: 03/31/11, 04/19/11

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates. Low Back

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is male who sustained a work related injury to his low back on xx/xx/xx. The claimant fell through a hole in the floor of a trailer with his right leg. His right leg became jammed and as he tried to get himself out of the hole he developed low back pain. The claimant was initially treated with physical therapy and an epidural steroid injection without relief. A lumbar MRI dated 08/04/10 revealed a 5 millimeter retrolisthesis of L2 and L3 with a superimposed 5 millimeter broad-based posterior protrusion. A 2 millimeter broad-based posterior protrusion was noted at L4-5 and L5-S1. A 2 millimeter retrolisthesis was noted at L3 and L4 without superimposed protrusion. A 1-2 millimeter broad-based spondylitic posterior protrusion was noted at L1-2. Minimal bilateral foraminal stenosis was noted at L1-2 and L2-3. A bilateral spondylosis was noted at L5 without evidence of associated spondylolisthesis on L5 on S1. Multiple bilateral lumbar facet arthroses were noted. A lumbar CT scan on 08/04/10 showed a 5 millimeter retrolisthesis of L2 on L3 with superimposed 5 millimeter broad-based posterior protrusion. There was 2 millimeter spondylolisthesis of L5 on S1 with superimposed 1-2 millimeter broad-based posterior protrusion. There was bilateral L5 spondylolysis and a subtle 2 millimeter broad-based posterior protrusion at L4-5 level. There was 2-3 millimeter retrolisthesis of L3 on L4 without superimposed protrusion, a 2 millimeter retrolisthesis of L1 on L2 with a superimposed 1 millimeter broad based spondylolytic posterior protrusion. There was mild bilateral neural

foraminal stenosis at L1-2 and L2-3 levels and mild multilevel bilateral lumbar facet arthrosis. The claimant had a bilateral L5 pars injection on 03/01/11 without relief. When he saw Dr. on 03/14/11, the claimant complained of low back pain that he rated as 9/10. On examination the claimant was tender throughout the lumbar spine. Dr. recommended a discogram which was noncertified in two peer reviews dated 03/31/11 and 04/19/11.

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

Review of the records provided supports the claimant is a gentleman who reported back injury. The claimant reports back pain. He has been treated in the past with physical therapy. There are no clear MRI findings or psychologic evaluation to see if the claimant is a good candidate for surgery or a discogram. It is not clear they have exhausted conservative care. An MRI demonstrating degenerative disc has not been provided. It is not clear if the claimant has undergone a detailed psychosocial assessment and has been briefed on the potential benefits and risks of the proposed procedure and surgery. Based on review of the records provided, evidence-based medicine and Official Disability Guidelines, the reviewer finds that Lumbar Discogram at L2-L3, L5-S1 with Control level of L4-L5 followed by CT is not medically necessary at this time.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates. Low Back

Discography is Not Recommended in ODG

Patient selection criteria for Discography if provider & payor agree to perform anyway

- o Back pain of at least 3 months duration
- o Failure of recommended conservative treatment including active physical therapy
- o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)
- o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided)
- o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) (Carragee, 2006) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria
- o Briefed on potential risks and benefits from discography and surgery
- o Single level testing (with control) (Colorado, 2001)
- o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)