

CareReview™

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 19, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar provocative discography L3-4, L4-5, L5-S1 (MD plan notes; lumbar provocative discography L3-4, L4-5, L5-S1 with additional pain control level L2-3, post discography lumbar CT scan)

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

This physician is a Board Certified in Pain Medicine with over 40 year of experience.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On August 25, 2008, M.D., a neurosurgeon, evaluated the claimant. The claimant's low back pain has not improved. No physical examination was noted. Recommendation: Lumbar MRI.

On April 7, 2010, M.D. evaluated the claimant. The claimant has undergone injections without any improvement. Assessment: Displacement Lumbar intervertebral disc without myelopathy. The claimant has a ruptured disc at L3-4, L4-5, and L5-S1. She is still suffering from severe pain in the lower back. I will recommend the claimant have discogram to determine which disc is positive for pain.

On June 4, 2010, MRI of the Lumbar Spine was performed. Impression: L3-4 demonstrates a 2mm disc herniation. There is a loss of T2 signal at L4-5 with a 2 mm

disc herniation. There is a mild loss of T2 signal L5-S1. There is a 2-3mm disc herniation at L5-S1.

On April 6, 2011, M.D. evaluated the claimant. Assessment: Low back pain. Muscle spasm. Lumbar radiculopathy. Discogenic syndrome. Neck pain.

On April 20, 2011, M.D. performed a UR on the claimant. Discography is not recommended. Denial: There is no objective documentation of formal rehabilitative efforts done to the claimant. Follow-up reports were not provided to validate progression of neurologic deficits in this claimant. The required psychological evaluation is not available for review.

On April 28, 2011, M.D. performed a UR on the claimant. Discography is not recommended. Denial: The lumbar MRI from 8 months ago revealed minimal L3-S1 disc protrusions, without mention of nerve root encroachment or canal stenosis. There is no mention of any possible surgical intervention planned. There is also an absence of failed pain management and psychological evaluations.

On May 16, 2011, M.D. evaluated the claimant. Physical Examination: Positive right SLR. Negative Fabere test. Light touch and pain sensation deficit noted to right lower extremity. Assessment: Neck pain. Low back pain. Discogenic syndrome. Lumbar radiculopathy. Muscle Spasm.

PATIENT CLINICAL HISTORY:

The claimant injured her cervical and lumbar spine while attempting to open a heavy door the door fell on her.

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

First, There is no documentation that surgical intervention is planned. Secondly, there is no documentation that a pain management program has been completed or that the claimant has failed conservative treatment. Furthermore, the MRI of the lumbar spine only shows minimal changes with no mention of nerve root encroachment or canal stenosis. Based on the ODG the discography is not recommended; therefore, the previous decisions are upheld.

Per the ODG:

Discography is Not Recommended in ODG.

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

- Back pain of at least 3 months duration
- Failure of recommended conservative treatment including active physical therapy
- 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)
- 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)

- 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.
- Briefed on potential risks and benefits from discography and surgery
- Single level testing (with control) ([Colorado, 2001](#))
- 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- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- 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)