

**ReviewTex. Inc.**  
**1818 Mountjoy Drive**  
**San Antonio, TX 78232**  
**(phone) 210-598-9381 (fax) 210-598-9382**  
**reviewtex@hotmail.com**

**Notice of Independent Review Decision**

**Date notice sent to all parties:**

July 30, 2014

**IRO CASE #:**

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

Discogram L3-4, L4-5; 62290 x 2- injection procedure for discography, each level, lumbar; 72295 x 2 – discography, lumbar, radiological supervision and interpretation; 72132 – computed tomography, lumbar spine; with contrast material.

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

Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury to his low back. The peer review dated 04/30/12 indicates the patient complaining of low back pain with radiating pain into the lower extremities. Moderate tenderness was identified in the lumbar spine. 4/5 strength was identified with the hip flexors and extensors as well as with external rotation and internal rotation of both hips. 3/5 strength was identified with abduction. The note indicates the patient utilizing Norco and Flexeril for pain relief. The MRI of the lumbar spine dated 04/11/13 revealed a disc protrusion at L5-S1. A posterior displacement was identified at the left S1 nerve root. Moderate bilateral

neuroforaminal narrowing was also revealed. A 5-6mm broad based posterior disc protrusion was identified at L4-5 with mild bilateral neuroforaminal narrowing. A disc bulge was also identified at L3-4. The operative report dated 04/23/13 indicates the patient undergoing medial branch blocks at L3 through L5. The operative note dated 10/02/13 indicates the patient undergoing an L5-S1 hemilaminectomy with a partial facetectomy on the left. The therapy note dated 12/17/13 indicates the patient having completed 12 postoperative physical therapy sessions to date. The clinical note dated 12/19/13 indicates the patient stating the postoperative therapy was providing no significant benefit. The patient continued with 3/10 pain. The note also indicates the patient utilizing Hydrocodone, Flexeril, and Mobic for pain relief. The clinical note dated 03/20/14 indicates the patient continuing with 5/10 low back pain. The patient stated that he was having difficulty completing his activities of daily living. The clinical note dated 04/10/14 indicates the patient continuing with progressive levels of pain that were rated as 6/10 in the low back. The note indicates the patient having undergone an MRI of the lumbar region on 03/31/14 which revealed posterior bulges at L3-4, L4-5, and L5-S1. Bilateral arthropathy was identified at L3-4 without significant stenosis. The patient was being recommended for a discogram at that time.

The utilization review dated 06/04/14 resulted in a denial for the requested diagnostic procedures as recent high quality studies regarding discography have significantly questioned its use.

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

The documentation indicates the patient complaining of ongoing low back pain despite a previous surgical intervention. Currently, recent high quality studies have significantly questioned the use of discography results as a preoperative indication. Given the recent development indicating that the use of discography is questionable, this request is not indicated as medically necessary. Additionally, the patient has recently undergone an MRI which revealed significant findings at the L3-4, L4-5, and L5-S1 levels. No information was submitted regarding the patient's development of new symptomology or pathology. Therefore, the additional request for a CT scan of the lumbar region is not fully indicated.

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

**X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**