

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Sep/04/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Discogram L4-5

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Orthopedic Surgeon (Joint)

**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 medical necessity exists for each health care service in dispute.** It is the recommendation of this reviewer that the request for a discogram L4-5 is not medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** Patient is a male who was seen in clinic on xx/xx/xx. At that time he presented with pain and numbness. It was noted he had had 2 epidural steroid injections, and had completed 12 sessions of physical therapy that helped less than 50%. He was also using a TENS unit that gave mild relief. He stated he was injured as a result of lifting an object at work. Medications included Gabapentin and Hydrocodone. On physical examination the patient had positive straight leg raise in both the seated and supine position for low back pain. Range of motion was restricted. A previous MRI dated 02/03/14 apparently revealed a broad based left disc protrusion at L4-5 without spinal canal stenosis with left neuroforaminal narrowing. The previous EMG and nerve conduction study was apparently negative for radiculopathy or neuropathy. Upon exam reflexes were all rated at 1/4 in the bilateral lower extremities, and strength was measured at 5/5 in all muscle groups tested in the lower extremities. The patient exhibited ability to toe and heel walk. A discogram was recommended. It was noted the next step would be a surgical intervention for an L4-5 transforaminal lumbar interbody fusion.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** On 06/17/15, an adverse determination notice was submitted for the requested discogram at L4-5 and Official Disability Guidelines back chapter for discogram was the citing source. It was noted that given that discograms are controversial and not recommended according to Official Disability Guidelines, and given the clinical information provided, the request was not medically necessary. On 06/30/15, an adverse determination notice was also submitted for the requested discogram at L4-5 as Official Disability Guidelines do not recommend discography noting recent high quality studies conclusion significantly questioning the use of this study as a preoperative indication for spinal fusions. Therefore the request was non-certified.

The provider has indicated that the discogram at L4-5 would be recommended and then the next step after that would be a fusion. Guidelines do not indicate that a discogram is

recommended. However, should it be performed, there should be documented pain of at least 3 months' duration, failure of recommended conservative treatment including active physical therapy, and an MRI demonstrating 1 or more degenerative discs as well as 1 or more normal appearing discs to allow for an internal control, satisfactory results from a detailed psychosocial assessment, and single level testing with control is recommended. For this individual, the records indicate the patient has had significant conservative care including physical therapy, injection therapy and medications. He has also used a TENS unit. An MRI was not provided for this review but the provider discusses an MRI revealing pathology only at L4-5. No psychosocial evaluation has been provided for this review. Therefore, with single level pathology noted by the treating provider, and without documented psychosocial evaluation, the rationale for this requested discogram at L4-5 has not been documented. It is the recommendation of this reviewer that the request for a discogram L4-5 is not medically necessary and the prior denials are upheld.

**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 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)