

# C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: [resolutions.manager@ciro-site.com](mailto:resolutions.manager@ciro-site.com)

**DATE NOTICE SENT TO ALL PARTIES:** Mar/21/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** L5-S1 discogram with control at L4-5 and post discogram CT

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D. - Board Certified Orthopedic Surgery

**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 this reviewer's opinion that medical necessity for L5-S1 discogram with control at L4-5 and post discogram CT is not established

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who was injured on XX/XX/XX while pulling boxes down from a top of a cooler. The patient developed complaints of low back pain and was initially treated with physical therapy. The patient's pain persisted despite injections as well as medications. MRI studies from XX/XXXX noted some disc bulging with stenosis at L5-S1 at the neural foramen that was moderate in severity. The patient was being followed by several physicians. The XX/XX/XX record noted that due to persistent low back pain with no neurological deficits the patient was recommended for lumbar discography with post discogram CT studies to rule out the L5-S1 level as a pain generator. The proposed discography studies as well as post-discogram CT was denied by utilization review on XX/XX/XX as discography was not recommended by current guidelines and there were no imaging reports available for review as well as the psychological assessment. The request was again denied on XX/XX/XX due to the lack of support in the current clinical literature as well as lack of documentation regarding psychological assessment.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** Discography has been used in the past as part of a pre-operative evaluation for consideration of surgical procedures to address low back pain only. The current literature has significantly questioned the use of discography results as an indication for lumbar surgical procedures such as fusion. The current literature has concluded that the evidence indicates discography is of limited diagnostic value. Furthermore, the current literature has demonstrated that the findings from this procedure do not correlate well with MRI findings. In this case, the records do not include any exceptional factors for proceeding with a discography procedure. There is no indication that all other reasonable methods of determining pain generators have been exhausted. Furthermore, the records do not include a recent psychological evaluation ruling out confounding issues that could possibly impact the results of the test. As such, it is this reviewer's opinion that medical necessity for L5-S1 discogram with control at L4-5 and post discogram CT is not established and the prior denials remain 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 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)