



DATE OF REVIEW: March 29, 2007

IRO Case #:

Description of the services in dispute:

Preauthorization request – Lumbar discogram/CT (computed tomography) at L2-4, L4-5, L5-S1 and L2-3.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is a fellow of the American Board of Orthopaedic Surgery. This reviewer is a fellow of the North American Spine Society and the American Academy of Orthopaedic Surgeons. This reviewer has been in active practice since 1990.

Review Outcome

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

Upheld

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.

Medical necessity does not exist for the item in dispute: Preauthorization request – Lumbar discogram/CT (computed tomography) at L2-4, L4-5, L5-S1 and L2-3.

Information provided to the IRO for review

Records Received from the State:

Letter from, 3/8/07, 1 page

Confirmation of receipt of a request for a review by an Independent Review Organization, 3/8/07, 4 pages

Request for a review by an Independent Review Origination, 3/7/07, 3 pages

Utilization review determination, 12/21/06, 2 pages

Reconsideration/appeal of adverse determination, 1/18/07, 2 page

Records Received from the Requestor:

MRI report, 11/28/05, 2 page

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Initial chart note, 10/16/06, 2 pages
Procedure note, 11/13/06, 1 page
Chart note, 11/27/06, 1 page
MRI report, 12/6/06, 2 pages
Chart note, 12/11/06, 1 page

Records Received from the Respondent:

Response to the request for IRO, 3/19/07, 2 pages
Procedure summary – low back, from the ODG, 8 pages
ACOEM Guidelines, 1 page
Occupational medicine practice guidelines, 40 pages
Preauthorization request, 12/18/06, 1 page
Notes from center, 12/14/06, 1 page
Notes from Centers, xx/xx/xx, 2 pages
Texas Workers' Compensation Work Status Report, 3/23/06, 1 page
Notes from Centers, 11/03/05, 2 pages
Texas Workers' Compensation Work Status Report, 11/03/05, 1 page
Notes from Centers, 11/10/05, 2 pages
Texas Workers' Compensation Work Status Report, 11/10/05, 1 page
Notes from Centers, 11/17/05, 2 pages
Texas Workers' Compensation Work Status Report, 11/17/05, 1 page
Notes from Centers, 12/06/05, 1 page
Texas Workers' Compensation Work Status Report, 12/6/05, 1 page
Notes from, MD, 12/14/05, 2 page
Texas Workers' Compensation Work Status Report, 12/14/05, 1 page
Notes from, MD, 12/21/05, 2 pages
History and physical, 12/21/05, 3 pages
Notes from, MD, 1 page
Texas Workers' Compensation Work Status Report, 12/21/05, 1 page
Pain management consultation note, 1/3/06, 2 pages
Notes from, MD, 1/4/06, 2 pages
Texas Workers' Compensation Work Status Report, 1/4/06, 2 pages
Procedure note, 2/2/06, 1 page
Follow up note, 2/16/06, 2 pages
Letter from, RN, BSN, CCM, 3/6/06, 1 page
Follow up note, 10/24/05, 2 pages
Order to attend examination, 3/17/06, 1 page
Letter from, MD, 3/20/06, 1 page
Procedure note, 4/3/06, 1 page

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Designated doctor evaluation, 4/10/06, 7 pages
Report of medical evaluation, 4/10/06, 1 page
Follow up note, 4/20/06, 2 pages
Procedure note, 4/20/06, 1 page
Letter from, MD, 5/8/06, 1 page
Texas Workers' Compensation Work Status Report, 5/8/06, 1 page
Range of motion exam, 5/22/06, 6 pages
Summary of records, 5/22/06, 1 page
Functional abilities evaluation, 5/22/06, 8 pages
Oswestry low back pain disability questionnaire, 5/22/06, 1 page
Pain questionnaire, 5/22/06, 1 page
Pain questionnaire, 5/22/06, 3 pages
Progress note, 5/30/06, 3 pages
Letter from, MD, 6/5/06, 1 page
Comprehensive re-examination, 12/19/06, 3 pages
Range of motion exam, 12/19/06, 2 pages
Biofeedback note, 12/22/06, 1 page
Biofeedback note, 12/28/06, 1 page
Letter from, DC, 1/2/07, 1 page
Biofeedback note, 1/5/07, 1 page
Functional abilities evaluation, 1/30/07, 4 pages
Low back pain disability questionnaire, 1/30/07, 1 page
Pain questionnaire, 1/30/07, 1 page
Pain questionnaire, 1/30/07, 3 pages
Letter from, DC, 2/15/07, 1 page
Activity notes, 12/29/06, 16 pages
IIBs pay care sheet, 1 page

Patient clinical history [summary]

The patient is a female who is reported to have sustained an injury to her low back on xx/xx/xx. On this date she felt a pulling sensation in her low back with the onset of pain after lowering some boxes onto a pallet. The record indicates that the patient was referred for an MRI (magnetic resonance imaging) of the lumbar spine on xx/xx/xx. This study reports a transitional vertebra at the lumbosacral junction, and suggests that the L5 vertebra is sacralized. There is moderate L4-5 spondylosis with minimal to moderate left foraminal stenosis and left facet arthrosis. There is no convincing evidence of impingement on the exiting nerve root. There is a small left lateral osteophyte at this level, which abuts, but does not clearly compress the exiting L4 nerve root. There is an incidental finding of right renal scarring and atrophy, with compensatory hypertrophy of the left kidney. The patient was referred for electrodiagnostic studies on 12/21/05. These studies

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find no evidence of an active left lower extremity radiculopathy. The patient was subsequently referred to Dr., a pain management specialist. On 02/02/06 the patient underwent a fluoroscopically guided left L4 and L5 epidural steroid injection. Postoperatively the injection is initially reported to have increased her leg symptoms; however, since then it has calmed down, and she reports about 50% relief. A second lumbar epidural steroid injection was performed on the left at L4 and S1 on 04/03/06. She is again reported to have sustained approximately 50% relief with these injections.

The patient was seen by designated doctor on 04/10/06. Dr. reports that the patient has been treated with conservative care, which has included physical therapy and two injections. She further reports that the patient is not considered a surgical candidate at this time. The patient presents with continued complaints of pain in the low back, mid back, left hip, and left leg accompanied by numbness and tingling. On physical examination the patient is reported to be overweight and cooperative. She ambulated into the examination with a normal gait. The patient was able to sit comfortably. Palpation of the lumbar spine revealed tenderness in the middle with spasm of the paravertebral muscles at L5-S1 bilaterally. There is no noted tenderness over the sacroiliac joints, posterior superior iliac spine, or buttocks. Test is reported to be positive on the right. Lumbar range of motion is decreased in flexion only. Lower extremity sensory testing is intact. Deep tendon reflexes are 2+ and symmetric. Lower extremity motor strength is rated as 5/5. Dr. opines that the patient has a lumbar herniated disc and that she has reached MMI (maximum medical improvement) on 04/10/06. She finds the patient to have a DRE category 2, and assesses a 5% whole person impairment.

The patient was seen in follow up by Dr. on 04/20/06. He reports that the patient has previously had epidural steroid injections, and the severe low back and all the leg pain is gone after the injections. She has a few spots in the low back and buttock that are painful, with some continued right lower extremity pain. As a result, she is recommended to continue physical therapy and she was continued on oral medications.

The patient underwent an IME (independent medical examination) on 05/22/06. At this time Dr. indicates that the patient sustained an injury to her low back. He further notes that the patient has facet arthrosis. He opines that the patient is a surgical candidate for discectomy at L4-5, but notes that given the patient has responded to epidural steroid injections, he recommends a third injection. It would be further noted that the patient underwent a functional capacity evaluation, which indicated that the patient provided inconsistent effort, and submaximal effort. As a result, the patient's physical demand level was indeterminate. The patient was later referred to Dr. on 05/30/06 for surgical evaluation. At this time the patient reports that she has been working part time. She continues to have low back pain and radiation into the left lower extremity, and further reports right leg pain all the way to the toes. The patient's past medical history is non-

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contributory. On physical examination she has tenderness over the lumbosacral junction from L4 to S1. Range of motion is limited in all planes. Manual motor and sensory examination is intact, except for light touch and pinprick loss in the left lateral aspect of the leg. Hip flexion, knee extension, dorsiflexion and plantar flexion of the foot and ankle are 5/5. Straight leg raising is negative. Cross straight leg raising is negative. There is no muscle atrophy present. Heel/toe gait is intact. Dr. opines that the patient has adjacent joint breakdown at L4-5. He reports that she has only four non-articulated lumbar vertebrae, and she has Modic endplate changes at L4-5 and slightly at L3-4. He further reports that the actual injury was secondary to lifting, aggravating a preexisting degenerative condition at the L4-5 level. He reports that the patient has a previous fusion of the L5-S1 segment, leaving her with significant adjacent joint breakdown at L4-5. He recommends a TLIF at L4-5 versus a total disc replacement. He notes that her facet joints are arthritic, and therefore not ideal for total disc replacement.

On 10/16/06 the patient was seen by Dr. The patient reports that she has significant low back pain, with a secondary complaint of bilateral lower extremity pain. Her pain reportedly extends down to the ankles and soles of her feet. She has previously undergone 3 weeks of therapy and epidural steroid injections. She further reports that she was offered surgical intervention by Dr., which was denied by the carrier. On physical examination the patient has reduced lumbar range of motion. Lateral bending to the left side hurts. Extension and rotation bilaterally hurts to the left side. In the seated position she has intact and brisk deep tendon reflexes at the knees and ankles. Straight leg raising is negative. Lasegue's test is negative. Motor strength is reported to be 4/5 on the left EHL. Dr. recommends that the patient undergo a series of facet blocks. The patient underwent facet blocks on 11/13/06. Post procedurally she is reported to have gotten good positive response during the anesthetic phase. Dr. further recommends a repeat lumbar MRI to evaluate the disc at the L3-4 level.

The patient underwent an MRI scan without contrast on 12/06/06. This study reports that the lumbar spine has a transitional appearance. The same counting convention as used on the report of the lumbar spine MRI dated 11/08/05 is used for this study. The L5 body is assumed to be sacralized with a partially formed L5-S1 disc. Using this counting convention, a benign incidental hemangioma is present within the upper L1 body and the conus terminates at the upper L2 level. This study further reports no central or right foraminal stenosis in the lumbar spine. There is a 2 mm bulge at L4-5 more prominent to the left of midline. The bulge and moderate left facet joint hypertrophy caused mild stenosis of the left L4-5 foramen. There is no other foraminal stenosis in the lumbar spine. At L3-4 there is a 1 mm bulge that slightly flattens the ventral surface of the thecal sac. Bilateral facet hypertrophy is present at L3-4 and L4-5. The patient was seen in follow up on 12/11/06. On this date Dr. discusses the information noted above and recommends that the patient undergo lumbar discography at L3-4, L4-5 and L5-S1 with L2-3 to be utilized if necessary as a control.

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Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The available records indicate that the patient has a long-standing history of low back complaints. The records do not include a pre-procedure psychiatric evaluation. Given that the patient has a long standing history of intractable pain and has been reported to have provided a submaximal effort on FCE (functional capacity evaluation), this study would be essential to considering this request. Provocative discography is controversial at best, and there is no way to gauge the validity of a patient's response. Further, the request potentially involves four levels. If all evoke some form of response, the test would be invalid. ACOEM reports, "Recent studies on discography do not support its use as a preoperative indication for either intradiscal electrothermal (IDET) annuloplasty or fusion. Discography does not identify the symptomatic high intensity zone, and concordance of symptoms with the disk injected is of limited diagnostic value (common in non back issue patients, inaccurate if chronic or abnormal psychosocial tests), and it can produce significant symptoms in controls more than a year later. Tears may not correlate anatomically or temporally with symptoms. Discography may be used where fusion is a realistic consideration, and it may provide supplemental information prior to surgery. This area is rapidly evolving, and clinicians should consult the latest available studies. Despite the lack of strong medical evidence supporting it, discography is fairly common, and when considered, it should be reserved only for patients who meet the following criteria:

- Back pain of at least three months duration.
- Failure of conservative treatment.
- 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.)
- Is a candidate for surgery.
- Has been briefed on potential risks and benefits from discography and surgery.

A description and the source of the screening criteria or other clinical basis used to make the decision:

The American College of Occupational and Environmental Medicine Guidelines. Accessed: 02/02/2007. Chapter 12.

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