MEDICAL REVIEW OF TEXAS

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DATE OF REVIEW: **APRIL 5, 2007**
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar Discogram followed by plasma disc decompression

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
MD, Board Certified Orthopaedic Surgeon

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

X 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

- Peer Review and re-read MRI
- medical records
- medical records
- Medical records from MD; Low Back Pain Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:
On xx/xx/xx, performed a review of the requested healthcare services for the claimant. The diagnoses were intervertebral disk disorder and lumbago. The requested procedures were special supplies, inject for spine disk x-ray, and percutaneous discectomy. The recommendation of this review was non-authorization of the procedure. Dr. reported that he had attempted to contact Dr. office and had left a message. The claimant was apparently reporting axial back pain with no lower extremity symptoms. The pain was increased with social activities as well as lying prone and side lying. The patient had a history of previous low back pain and had apparently been offered surgery 5 years preceding this occurrence but had not had surgery and had done well and continued to work. An MRI on xx/xx/xx revealed a 5 to 6mm broad based paracentral disc protrusion at L5-S1, deformity of the left S1 nerve root sleeve without central canal stenosis but there was noted to be some left lateral recess narrowing and also a small degree of lateral recess narrowing at L4-5 due to a 2 to 3mm bulge of the annulus and facette hypertrophy. The reviewer noted no documentation of physical therapy or injections and no evidence of functional

limitations and no report of leg pain. Considering those factors, it was Dr. opinion that further conservative care was warranted and the medical necessity of lumbar discectomy had not been established.

On 2/18/07, a second review was performed by by Dr. He recommended denial of the authorization of the procedure. He noted the claimant presented with chronic axial low back pain and had no leg pain and that prior diagnostics had shown three abnormal disks at L3-4, L4-5 and L5-S1. It was Dr. opinion that the requested intervention was not supported as proving long term objective or functional benefits in evidence based medicine literature. He referenced the *ODG-TWC Low Back Procedure Summary* last updated xx/xx/xx as well as *Guidelines for Lumbar Fusion from The Washington State Department of Labor and Industries*.

Prior to these two reviews on 2/18/06 Dr. reviewed the medical records. He noted that the patient had received some prescription medications in October 2006 and had an MRI reread on 12/12/06. He noted she was a flight attendant who had complained of low back pain after pushing and pulling a bar car during a flight. He reviewed the MRI findings, which are noted above. He noted that she had a previous work related history of lower back injury and had had a previous MRI, which he did not have available for review. It was stated that she had had back pain off and on since that previous injury but no treatment in the last five years.

He noted little medical information regarding her physical findings. With the MRI findings in mind he felt that if she showed objective signs of radiculopathy that epidural steroids might be indicated. He felt that if she had no objective signs of radiculopathy then epidural steroids would not be indicated. He noted that the findings on the MRI might be pre-existing. He felt that one or two epidural steroid injections would be indicated if she had objective radicular symptoms as well as physical therapy. He stated that he could not determine whether the current symptoms were related to the single work related injury in questions. He stated that if the claimant had not sought treatment for the past five years and had not been on any medications then her current symptoms were probably related to a more recent event such as work related injury.

Subsequent to this there is a second opinion MRI scan on the claimant done 11/7/06. Dr. reviewed the MRI and noted a 4mm broad based left paracentral disk protrusion at L5-S1 indenting the left anterior thecal sac and mildly effacing the left S1 nerve root. He also noted 3mm broad based posterior central disk protrusion at L4-5 and a mild posterior disk bulge at L3-4 as well as multilevel facette degeneration most prominent at L4-5. The claimant also had moderate bilateral foraminal narrowing at L4-5 and L5-S1 and to a lesser extent at L3-4.
On 10/9/06, there is a physical therapy prescription for the claimant with a diagnosis of lumbar strain from Center.
On 10/11/06, the claimant underwent a physical therapy evaluation. She was complaining of lower lumbosacral and right iliac area pain, which had begun

during employment on xx/xx/xx when she pulled a heavy beverage cart. She reported that continued work had aggravated her pain. She did not mention any lower extremity pain. There was past history of herniated lumbar disk in the 1980's, which had resolved conservatively. Examination revealed no strength deficits. Knee jerk was noted to be mildly diminished on the right side and on the left side, both being 1+. She had a negative straight leg raising at 85 degrees on the left and 75 degrees on the right. She had a negative Lasegue's sign. Therapy was recommended over a four week time frame.

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

THE CLAIMANT PRESENTS WITH A HISTORY OF WORK RELATED BACK INJURY WITH. IMAGING STUDIES DEMONSTRATE DEGENERATIVE LUMBAR DISK DISEASE AT MULTIPLE LEVELS WITH THE L5-S1 DISK SHOWING A MODERATE DISK PROTRUSION POSSIBLY IMPINGING ON THE LEFT S1 NERVE ROOT AS WELL AS SOME FORAMINAL STENOSIS AT MULTIPLE LEVELS. THE MEDICAL RECORDS DO NOT REFLECT ANY OBJECTIVE FINDINGS OF RADICULOPATHY IN THE LOWER EXTREMITIES. BASED ON THE LACK OF CONCORDANT FINDINGS SURGICAL INTERVENTION IS NOT INDICATED AS NOTED ON THE REVIEWS, WHICH INDICATE THAT ONLY STRONG CONCORDANT PREOPERATIVE PHYSICAL AND IMAGING FINDINGS PREDICT A REASONABLE SURGICAL OUTCOME. THE PROPOSED PROCEDURE OF LUMBAR DISKOGRAMS FOLLOWED BY PERCUTANEOUS DISKECTOMY IS LIKEWISE NOT MEDICALLY REASONABLE OR NECESSARY. THE *ODG-TWC LOW BACK GUIDELINES* INDICATE THAT DISKOGRAPHY IS NOT RECOMMENDED DUE TO UNRELIABILITY, THE UNRELIABILITY OF DISKOGRAPHY AS A PREOPERATIVE INDICATION FOR EITHER IDTE OR SPINAL FUSION. THIS GUIDELINE ALSO INDICATES THAT THE PATIENT'S SPECIFIC BACK COMPLAINTS ON INJECTION OR THE CONCORDANCE OF SYMPTOMS IS OF LIMITED DIAGNOSTIC VALUE.

THE *UPDATE NO. 2* ON PAGE 344 NOTES THAT THE HAS BEEN AND REMAINS CONTROVERSIAL.

FURTHERMORE, THE *GUIDELINES* PAGE 304 INDICATES "RECENT STUDIES ON DISKOGRAPHY DO NOT SUPPORT A CHOICE AS A PREOPERATIVE INDICATION FOR EITHER." ADDITIONALLY, ON PAGE 306 STATES THAT PERCUTANEOUS DISKECTOMY IS NOT RECOMMENDED BECAUSE PROOF OF ITS EFFECT HAS NOT BEEN DEMONSTRATED FOR LUMBOSACRAL NERVE ROOT DECOMPRESSION.
THEREFORE, ALMOST ALL RELIABLE MEDICAL LITERATURE WOULD NOT SUPPORT THE USE OF DISKOGRAPHY AND PERCUTANEOUS DISKECTOMY FOR AXIAL BACK PAIN WITHOUT RADICULAR SYMPTOMS.

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 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**
- **X 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**
  1. ***OCOEM GUIDELINES***
  2. ***ORTHOPAEDIC KNOWLEDGE UPDATE NO. 2***
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**