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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 12-14-08

IRO CASE #:

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

This case was reviewed by a PM & R (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar discogram

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- August 23, 2007 - October 17, 2008 Office visits notes, 6 pp from Dr.
- September 7, 2007 Operative Report from Dr
- December 7, 2007 MRI lumbar spine read by Dr.
- May 23, 2008 MRI of the hips read by Dr.
- July 11, 2008 Electrophysiology exam from Dr.
- July 11, 2008 Neurology report from Dr
- July 14, 2008 Medical Report from Dr. Stauch, 8 pp.
- September 23, 2008 Notice of IRO decision from . regarding lumbar surgery
- October 27, 2008 Radiology report read by Dr
- November 4, 2008 Medical report from Dr.
- November 10, 2008 Letter of non-certification - request for lumbar discogram
- November 19, 2008 Letter of non-certification - request for appeal lumbar discogram
- December 8, 2008 Assignment of IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a xx-year-old employee who sustained an industrial injury to the low back on xx/xx/xx while changing heavy batteries. The claimant was examined by his physician for a lumbar strain. The claimant was known prior to this provider for depression, anxiety and a sprained ankle.

The medical records indicate the patient was prescribed medications and placed on light duty on January 5, 2007. The patient initially improved with chiropractic manipulation, however on August 23, 2007 was noted to have acutely worsened for 3 days. Lumbar MRI of August 23, 2007 shows "early degenerative disc disease associated with a broad-based mildly compressive

central/left paracentral disc protrusion or disc bulge at L4-5 without canal or foraminal stenosis. At L3-4 and L5-S1 no significant disc findings are noted."

The patient underwent minimally invasive laminectomy and discectomy with aid of a microscope on September 7, 2007 for left-sided L4-5 herniated nucleus pulposus resulting in significant left lower extremity radiculopathy. Postoperatively, the claimant participated in physical therapy but developed right leg pain in the middle of November 2007, 11 months after his on-the-job injury.

Epidural steroid injections were provided on December 19, 2007 and February 12, 2008 with benefit noted at the February 27, 2008 reevaluation. Right lumbar facet injection was administered on April 16, 2008.

Repeat MRI of May 8, 2008 per the reading radiologist, shows "early intradiscal dessication. There is a broad-based mildly compressive central/left paracentral disc herniation. This produces some effacement of the left subarticular recess and proximal left neural foramen without evidence of canal stenosis."

The patient underwent MRI of the hips on May 23, 2008 for bilateral hip and groin pain and lumbar radiculopathy. The examination was interpreted as normal.

The patient initiated treatment with a neurologist in June 2008 for low back pain and bilateral lower extremity pain. The patient was reported to have undergone a right lumbar facet injection at L3-4 and L4-5 on April 16, 2008 with some relief of pan. The assessment was lumbar radiculopathy with severe pain in the right lower extremity.

Electrodiagnostic studies were performed on July 11, 2008 for bilateral pain in the medial aspects of both legs and some left calf weakness. The physical examination revealed normal gait and normal lower extremity sensation. Some left calf atrophy was appreciated. The updated MRI of May 2008 was interpreted to show "extension of his left paracentral herniated disc at L4-5, compared to the December 2007 study." EMG revealed a left S1 radiculopathy with denervation potentials in both paraspinals.

A Designated Doctor Examination was conducted on July 14, 2008. The employer will not accommodate restrictions for this patient. His health history is significant for depression and anxiety. He had a laminectomy September 2007. He developed right leg pain in November 2007. He underwent lumbar epidural injections in December 2007 and February 2008. He did well for about 2 weeks and then the left lag pain returned. It was suspected that due left calf and thigh atrophy he may have a recurrence of the herniation. The repeat MRI of May 2008 did not show compression and he was sent for electrodiagnostic studies to clarify radiculopathy. EMG revealed a left S1 radiculopathy. His main pain is in both hips and the medial aspects of the left and right legs above the ankle with occasional numbness and tingling around the left great toe. Vicodin and lying down ease his pain. His pain level varies from 5-8/10. He experiences left leg weakness several times per day. His lumbar range of motion is markedly restricted. Neurologically he is grossly intact. There appears to be some left-sided disc protrusion at L4-5 per the examiners interpretation. Waddell's testing notes he has 5 out of 8 positive which is "significant for symptom magnification." No muscle spasm is present. There are no lesions on MRI capable of producing right sciatica. Diagnosis includes, complaints of persistent low back pain down both legs to the ankle and left thigh and calf atrophy with otherwise intact neurologic function. The patient is determined to be MMI with 10% whole person impairment.

The provider requested lumbar laminectomy with discectomy at L4-5 on the right which was not certified in review. An appeal was made and was not certified by an Independent Reviewer on September 23, 2008 with rationale that the medical records failed to document nerve root compression on the right. It was noted that relief with facet blocks does not support a procedure designed to relieve radiculopathy. Additionally, repeat MRIs post-op the 2007 surgery on the left failed to reveal anything on the right side for which the surgery was proposed.

Treatment notes of October 17, 2008 indicate the patient's right leg pain is a lot worse than is left. He has noticed some bladder urgency over the past month.

Updated lumbar MRI was performed on October 27, 2008 with interpretation of "central to left-sided disc protrusion, annular tear in narrowing of the left neural foramen at L4-5. Very small central disc protrusion at L5-S1 does not appear to affect nerve roots or significantly narrow the canal. Mild bilateral neural foraminal narrowing at L2-3." It is noted that there is mild loss of disc height at L4-5 while the other disc are normal in height.

The patient was seen in follow-up by his neurologist provider on November 4, 2008. The patient reports low back pain and bilateral lower extremity pain and numbness in the left foot. He reports also weakness in the bilateral lower extremity. The patient brings a lumbar MRI report. The patient reports increased back and leg pain described as 9/10 in intensity that significantly interferes with his sleep. He states he must sit and rest after walking about 100 feet. Vicodin at 3-4 pills daily provides minimal relief. He is using Oxycodone HCL. The examination is significant only for 4/5 motor strength in the right gastrocnemius-soleus and limited range of motion. Straight leg is noted as positive without further clarification. The MRI films of November 3, 2008 show "a broad-based HNP at L5-S1; a HNP at midline L4-5. A high intensity zone on the T2 weighted images seen at L4-5. There is mild degenerative disc disease (some dessication, little to no loss of disc height) at L5-S1. There is moderate degenerative disc disease (frank dessication, definite loss of disc height) at L4-5." Assessment is HNP-lumbar and degeneration of lumbar disc. Recommendation is for discography, lumbar, radiological supervision and interpretation.

Request for discography was not certified in review on November 10, 2008 with rationale that ODG does not recommend discography as recent high quality studies have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. A peer-to-peer discussion was attempted several times but not realized.

Request for appeal of lumbar discography was not certified in review following a peer-to-peer discussion with the provider on November 19, 2008 with rationale that, per the Official Disability Guidelines, recent studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) is of limited diagnostic value. Discography has not role in identifying radiculopathy. It is rather a confirmatory test in the workup of axial back pain. W hile not recommended, if it is to be used anyway the criteria for use are: back pain of more than 3 months duration, failure of conservative treatment, MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs and satisfactory results from a detailed psychological assessment. Discography can produce significant symptoms in controls more than a year later. The reviewer noted that the medical records did not support clear rationale for discogram which is usually a fusion.

The provider responds with request for an IRO.

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

The claimant has undergone microdiscectomy and laminectomy at L4-5 for a left-sided herniation. He has indications per MRI, EMG and examination findings of a recurrent left-sided herniation. The patient also has some right-sided symptoms but was appropriately not certified for a surgical intervention on the right. Discography has been requested without clarification of the treatment plan after discography. The patient has strong indications of symptom magnification during the DD examination and would require psychological assessment for discography which has not been documented.

The Official Disability Guidelines do not support discography. It has simply not been found in studies to be effective for identifying concordant pain and the study itself can leave patients with residual symptoms for a year. For this reason a detailed psychosocial assessment is required prior to considering discography. ODG state that "discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion (but a positive discogram in itself would not allow fusion. The medical records fail to document indications that would warrant a fusion procedure or that a fusion procedure is planned. Additionally, ODG specifically state that "due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification." On a final note, guidelines state that to warrant discography there should be an MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection), which is not the case for this patient as MRI results state there is mild loss of disc height at L4-5 while the other disc are normal in height. The medical records fail to document a medical necessity for discography. Therefore, my determination is to uphold the previous non-certification of request for outpatient lumbar discogram.

The IRO's decision is consistent with the following guidelines:

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 (PROVIDE A DESCRIPTION)

_____OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

The Official Disability Guidelines - 12-3-2008:
Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) is of limited diagnostic value. (Pain production was found to be common in non-back pain patients, pain reproduction was found to be inaccurate in many patients with chronic back pain and abnormal psychosocial testing, and in this latter patient type, the test itself was sometimes found to produce significant symptoms in non-back pain controls more than a year after testing.) Also, the findings of discography have not been shown to consistently correlate well with the finding of a High Intensity Zone (HIZ) on MRI. Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion (but a positive discogram in itself would not allow fusion). (Carragee-Spine, 2000) (Carragee2-Spine, 2000) (Carragee3-Spine, 2000) (Carragee4-Spine, 2000) (Bigos, 1999) (ACR, 2000) (Resnick, 2002) (Madan, 2002) (Carragee-Spine, 2004) (Carragee2, 2004) (Maghout-Juratli, 2006) (Pneumaticos, 2006) (Airaksinen, 2006) Discography may be supported if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not justify fusion). Discography may help distinguish asymptomatic discs among morphologically abnormal discs in patients without psychosocial issues. Precise prospective categorization of discographic diagnoses may predict outcomes from treatment, surgical or otherwise. (Derby, 2005) (Derby2, 2005) (Derby, 1999) Positive discography was not highly predictive in identifying outcomes from spinal fusion. A recent study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. (Carragee, 2006) The prevalence of positive discogram may be increased in subjects with chronic low back pain who have had prior surgery at the level tested for lumbar disc herniation. (Heggeness, 1997) Invasive diagnostics such as provocative discography have not been proven to be accurate for diagnosing various spinal conditions, and their ability to effectively guide therapeutic choices and improve ultimate patient outcomes is uncertain. (Chou, 2008) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. (Cohen, 2005) Discography involves the injection of a water-soluble imaging material directly into the nucleus pulposus of the disc. Information is then recorded about the pressure in the disc at the initiation and completion of injection, about the amount of dye accepted, about the configuration and distribution of the dye in the disc, about the quality and intensity of the patient's pain experience and about the pressure at which that pain experience is produced. Both routine x-ray imaging during the injection and post-injection CT examination of the injected discs are usually performed as part of the study. There are two diagnostic objectives: (1) to evaluate radiographically the extent of disc damage on discogram and (2) to characterize the pain response (if any) on disc injection to see if it compares with the typical pain symptoms the patient has been experiencing. Criteria exist to grade the degree of disc degeneration from none (normal disc) to severe. A symptomatic degenerative disc is considered one that disperses injected contrast in an abnormal, degenerative pattern, extending to the outer margins of the annulus and at the same time reproduces the patient's lower back complaints (concordance) at a low injection pressure. Discography is not a sensitive test for radiculopathy and has no role in its confirmation. It is, rather, a confirmatory test in the workup of axial back pain and its validity is intimately tied to its indications and performance. As stated, it is the end of a diagnostic workup in a patient who has failed all reasonable conservative care and remains highly symptomatic. Its validity is enhanced (and only achieves potential meaningfulness) in the context of an MRI showing both dark discs and bright, normal discs -- both of which need testing as an internal validity measure. And the discogram needs to be performed according to contemporary diagnostic criteria -- namely, a positive response should be low pressure, concordant at equal to or greater than a VAS of 7/10 and demonstrate degenerative changes (dark disc) on MRI and the discogram with negative findings of at least one normal disc on MRI and discogram. See also Functional anesthetic discography (FAD).
Discography is Not Recommended in ODG.
Patient selection criteria for Discography if provider & payor agree to perform anyway:
o Back pain of at least 3 months duration
o Failure of recommended conservative treatment including active physical therapy
o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal

control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)
o 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)
o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) (Carragee, 2006) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However. all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria.
o Briefed on potential risks and benefits from discography and surgery
o Single level testing (with control) (Colorado, 2001)
o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification