P-IRO Inc.

An Independent Review Organization
835 E. Lamar Blvd., #394
Arlington, TX 76011
Fax: 866-328-3894

Notice of Independent Review Decision

DATE OF REVIEW: March 14, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar discogram, CT L3/4, L4/5, L5/S1

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Operative report, 08/24/01
MRI lumbar spine, 12/15/04
EMG result, 03/31/05
Impairment rating, Dr., 08/02/05
MRI lumbar spine, 01/30/07
Office notes, Dr., 09/10/07, 12/04/07
Initial Chart Note, Dr., 11/07/07
Peer review, Dr., 12/27/07
Office note, Dr., 01/08/08
Psychological Evaluation, 01/10/08
Review for repeat MRI, Dr., 01/23/08
Review, Dr. , 02/06/08
Review, Dr., 02/20/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old male who originally injured his back in xxxx for which he treated without improvement. Reportedly the claimant was determined to be at Maximum Medical Improvement on 04/13/03 with a 5 percent rating. On 12/09/04 he slipped and fell coming out of a freezer landing on his back side. A lumbar discogram performed on 08/24/01 was positive for mild provocation of pain with concordance at L4-5. A lumbar MRI of 12/15/04 revealed small posterolateral bulges without evidence of canal stenosis or nerve root impingement at L2-3; a 1 millimeter broad annular disc bulge with mild central canal stenosis at L3-4; and a 2 millimeter disc protrusion/herniation with mild central canal stenosis and mild bilateral neural foraminal narrowing at L4-5; and a 2 millimeter broad annular disc bulge with potential SI nerve root impingement centrally without significant central canal stenosis or neural foraminal encroachment at L5-S1.

EMG studies of 03/31/05 showed no evidence of lumbosacral radiculopathy. The claimant treated with chiropractics, medications and various injections. Dr. evaluated the claimant on 08/02/05 noting the claimant's complaints of numbness and burning along with totality of the posterior aspect of the left leg with sparing of the anterior space. He had significant examination findings and was diagnosed with multilevel spondylosis, mild stenosis at L3-4 and L4-5 and a lumbar strain and contusion to the gluteal area. He was declared to be at Maximum Medical Improvement as of that date and assigned a 5 percent impairment rating.

A lumbar MRI on 01/30/07 demonstrated a broad 1 millimeter disk bulge at L3-4 and L5-S1 with mild central canal stenosis at L3-4; and mild multifactorial central canal stenosis and mild bilateral neural foraminal narrowing with a broad 2 millimeter disk protrusion at L4-5.

Dr. evaluated the claimant on 09/10/07 with worsening low back pain in the left buttock radiating to the left lower extremity to the big toe despite therapy, corticosteroid injections, and medications. He had positive dysphoria. On examination there was a left sided limp, vertebral and left paraspinal tenderness to palpation, positive left straight leg raise, tenderness to palpation of the left buttock, hypoesthesia in the L5 and S1 and S2 nerve roots on the left, and 0 knee and ankle reflexes bilaterally. Displacement of the lumbar intervertebral disc without myelopathy and spasm were diagnosed and referral to Dr., Hydrocodone-APAP and Carisoprodol were recommended. At the 11/07/07 visit the claimant reported burning pain, impotence for a month with diminished libido. He had a history of diet controlled diabetes. X-rays on 11/07/07 including flexion/extension views showed 5 vertebra in good alignment without significant abnormalities. The examination noted extension and rotation were positive bilaterally. Dr. diagnosed the claimant with spondylosis at L3-S1, chronic lumbar radicular symptomatology, central stenosis at L3-5 and a herniated disc at L4-5. The claimant was declared a surgical candidate and a lumbar MRI and probable lumbar discography with psychological evaluation were advised. Reportedly the lumbar MRI was denied.

Dr. on 01/08/08 indicated that the MRI films of 01/30/07 were of relatively poor quality from which he was not comfortable making further clinical decisions on and thus recommended a high quality lumbar MRI and if not approved a lumbar discogram. A psychological evaluation was performed on 01/10/08 at which time it was stated that although there were minimal psychological factors, that he would make an excellent candidate for a lumbar discogram. The MRI was again denied and on 01/23/08 Dr. ordered lumbar discography to identify the pain generators as the claimant remained a surgical candidate. The lumbar discogram was denied on peer reviews of 02/06/08 and 02/20/08. The request is currently in dispute.

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

After a careful review of all medical records, the Reviewer's medical assessment is that, the lumbar discogram 3-4, 4-5, and 5-1 does not appear to be medically necessary and reasonable.

This is a xx-year-old male who in a report in the medical records has an MRI dated on xx/xx/xx which does not demonstrate degenerative disc levels noted. There were notations by Dr. on 01/08/08 that these were poor quality, and he had requested repeating those MRIs, but this was not done.

A psychological evaluation was also performed, which demonstrated he was reasonable candidate for undergoing lumbar discogram.

There was no documentation of recent conservative care including physical therapy. There were noted multiple levels which have been requested as opposed to single-level testing with a control. Based upon this, the Reviewer does not think he meets the guidelines or criteria per ODG for undergoing a discogram.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Low Back-Discogram)
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) 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).

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**
- ☒ **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)**