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DATE OF REVIEW: November 12, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar discogram at L3-L4, L4-L5, and L5-S1 (72295)

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

The physician providing this review is a spinal neurosurgeon. The reviewer is national board certified in neurological surgery. The reviewer is a member of the American Association of Neurological Surgeons, The Congress of Neurological Surgeons, The Texas Medical Association, and The American Medical Association. The reviewer has been in active practice for 38 years.

REVIEW OUTCOME

Overturned (Disagree)

Medical documentation **supports** the medical necessity of Lumbar discogram at L3-L4, L4-L5, and L5-S1 (72295)

ODG have been utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx, while loading lumber onto a truck and felt pain in his low back. Next day, he was pushing a cement pump and his pain became so severe that he had to stop working.

Initially, the patient was evaluated by the company doctor who x-rayed him and gave medications. D.C., evaluated the patient for persistent low back pain and muscles spasms and numbness and tingling in the legs bilaterally. He assessed acute moderate-to-severe lumbar sprain/strain with radiculopathy and recommended physical therapy (PT). D.O., noted positive straight leg raise (SLR) test bilaterally and prescribed Celebrex, Ultram, and Amrix. Magnetic resonance imaging (MRI) of the lumbar spine revealed bilateral facet synovitis at L3-L4 and L4-L5 and 1.5 mm asymmetric right disc protrusion at L4-L5 with right foraminal stenosis and mild disc desiccation.

D.O., an orthopedic surgeon, prescribed Flexeril and sent him for lumbar epidural steroid injections (ESIs). ; M.D., a pain specialist, performed a lumbar ESI followed by bilateral L3-L4 and L4-L5 facet joint median branch nerve blocks.

On March 10, 2008, M.D., a designated doctor, noted positive Waddell's signs

and placed the patient at clinical maximum medical improvement (MMI) with 5% whole person impairment (WPI) rating.

Dr. noted that there was no relief with the facet blocks. He recommended diagnostic bilateral sacroiliac (SI) joint injections based on tenderness over the SI joints and positive Patrick FABERE test. Dr. recommended chronic pain management and stated the patient was not a surgical candidate. In a physical performance evaluation (PPE), the patient qualified at a sedentary physical demand level (PDL).

M.D., a neurosurgeon, noted the patient had constant low back pain and radiating pain in the left leg along with numbness. He prescribed Pamelor, Relafen, and Robaxin. Electromyography/nerve conduction velocity (EMG/NCV) study of lower extremities was normal. Following this, Dr. recommended a lumbar discogram. A psychologist cleared the patient for discogram. On August 14, 2008, Dr. noted tenderness primarily in the left lower lumbar area, flexion of 45 degrees, extension and lateral bending of 5%, and bilateral SLR producing low back pain at 45 degrees. He assessed L4-L5 disc desiccation with bulge and chronic pain syndrome. He stated was the patient was a candidate for lumbar discogram at L3-L4, L4-L5, and L5-S1 as he continued to have intractable and intolerable pain.

On August 25, 2008, , M.D., denied the request for lumbar discogram with the following rationale: *“The date of injury is listed as xx/xx/xx. Previous treatment has included treatment in form of rehabilitation services as well as therapeutic injections. A physician assessment dated August 14, 2008, indicated that an electrodiagnostic assessment accomplished on May 27, 2008, was without an acute radiculopathy. A physician assessment dated August 14, 2008, did not document the presence of any neurological deficits on physical examination. It would appear that in the past, there was a declaration of MMI by a designated doctor. The records available for review would appear to indicate that a lumbar MRI obtained after the date of injury disclosed the presence of multiple levels of disc degeneration. At the present time, medical necessity for this request would not appear to be established. This requested diagnostic study is typically accomplished prior to consideration of lumbar spine surgery.”*

On September 29, 2008, an appeal was made with the following response: *“Interestingly, in reviewing the above denial, it would assume that a lumbar radiculopathy would need to be present for discogram to be appropriate. This is certainly not the case. As the physician advisor may understand, the determination of the discogram is to identify the appropriate pain generators and to establish internal disc disruption syndrome from which lumbar pain emanates. As to the presence of radiculopathy, this is certainly not an indication and certainly a discography should never be used to diagnose the presence of radiculopathy. Following criteria were applied to the patient for discography. (1) The patient has had back pain since his injury dated xx/xx/xx, and thus more than six months in duration. (2) He has failed a recommended course of conservative therapy including PT, chiropractic treatment, ESIs, facet injections, and medication management. (3) An MRI has been undertaken, which has revealed degenerative disc disease (DDD)/disc desiccation, and disc space narrowing at L4-L5. Normal-appearing discs are noted at the levels of L3-L4 and L5-S1. (4) Psychologically, he has been cleared for the discogram. (5) Dr. feels that lumbar surgery may be appropriate, but is looking to determine if it is not*

indicated. If discography in this case was undertaken does not identify the pain generator, then surgery would not be applicable. (6) Furthermore, the mere fact that the patient has been placed at MMI is not the reason as to deny further care.”

On October 20, 2008, M.D., denied the appeal for lumbar discogram with the following rationale: *“Based on the clinical information provided, the appeal request for lumbar discogram is not recommended as medically necessary. The patient is noted to have sustained lifting injury to the low back in xx/xxxx. MRI of the lumbar spine revealed facet synovitis at L3-L4 and L4-L5 with a 1.5 mm asymmetric right disc protrusion at L4-L5 with right neural foraminal narrowing. Dr. indicates that the patient’s primary complaint is left low back pain. A designated doctor found multiple signs of symptom magnification with possible Waddell’s signs. There is no indication of a surgical lesion. More over Official Disability Guidelines (ODG) reflect that recent high quality studies have questioned the use of discography as a presurgical indication.”*

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

Medical material reviewed for this case listed numerically:

1. The patient clinical summary through 10/20/08 supplied by Matutech, Inc.
2. Chiropractic initial reports of 12/10/07 and additional reports on 1/14/08, 3/27/08
3. Medical Clinical report by, D.O., 12/17/07
4. Lumbar MRI report, 12/17/07
5. 1/22/08 Orthopedic report by, D.O.
6. Pain Institute reports 2/2008 including an operative report on epidural steroid injections in the lumbar spine, 2/14/08, 2/28/08
7. History and physical report by, M.D., 5/7/08, 7/2/08, 8/14/08, 10/17/08
8. Electrodiagnostic testing report, 5/27/08
9. denial notices, 8/2008, 9/2008, 10/20/2008
10. Diagnostic neuro imaging reports

This case involves a male who was loading lumbar on xx/xx/xx and developed back pain. The next day the pain was made markedly more severe when he was pushing a cement pump. He had to stop work because the pain was so severe on that day. Physical therapy was not helpful. A lumbar MRI suggested multiple levels of difficulty with the primary level being at L4-5 with possible significant foraminal stenosis from disc herniation. Facet blocks and epidural steroid injections have not been helpful. An EMG on 5/27/08 failed to reveal any evidence of radiculopathy but on examination on 5/7/08 there was a deficit to pin prick suggesting nerve root compression on the left side. For additional evaluation a lumbar discogram has been recommended.

I disagree with the denial for the lumbar discographic evaluation. On the lumbar MRI and possibly on the physical examination findings, the L4-5 area is the most likely source of the patient’s pain. When a specific level is being evaluated for potential surgical intervention discography it is often very beneficial if it happens to be positive at that particular level and negative at other levels. In this case, a positive discogram at a level other than L4-5 would confuse the picture, but if it were positive at the L4-5 level only, it would be very beneficial with conclusions

about surgery at that level being the next step. It is not at all unusual to have a negative EMG when a nerve root is compressed with the major compression being in the sensory component. The patient has had multiple attempts at conservative management and at coming to conclusions that whether an open surgical procedure would be helpful is thought indicated and discography may be helpful in that regard.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**