

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 9, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of lumbar discogram L3-S1 62290.

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

MD, 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)

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.

The reviewer finds that medical necessity does not exist for lumbar discogram L3-S1 62290.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 9/17/08, 9/22/08

ODG Guidelines and Treatment Guidelines

Office note, Dr. , 02/05/08

Physical Performance Exam, 02/19/08

X-rays lumbar spine, 02/21/08

MRI, 03/05/08

Office note, Dr. , 05/19/08
Office notes, Dr. , 06/06/08, 07/11/08, 08/08/08, 09/05/08
ESI, 07/02/08, 08/01/08
Statement of Medical Necessity, 03/03/08
Prescription, 03/03/08
Pre-certifications, undated
Note, , 06/19/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old male injured on xx/xx/xx when he was turning and carrying objects and felt a pop in the low back. He treated with chiropractor Dr. for low back and bilateral leg pain to the calves.

The 02/21/08 x-rays of the lumbar spine showed L5-S1 disc space narrowing and mild facet arthrosis at L4 thru S1. On 03/05/08 an MRI documented L3-4 protrusion partially effacing the thecal sac and narrowing the spinal canal to 9 millimeters (mm), narrowing of the neural foramina on both sides, facet arthrosis and minimal effusion. There was an L4-5 protrusion effacing the fat and almost contacting the bilateral L5 nerve roots; right more than left foraminal narrowing and facet arthropathy; the canal was 8-9mm. At L5-S1 was a protrusion effacing the thecal sac; S1 nerve roots were not seen; and the canal diameter was 7-8mm indicating central stenosis.

The claimant had persistent back and leg pain that did not respond to therapy or various medications and he was referred for injections.

On 06/06/08 Dr. noted there was decreased sensation of the left lower extremity and reflexes normal with motor 3/5 on the left and 4/5 right. On 07/02/08 an L5-S1 epidural steroid injection was done. The claimant was seen on 07/11/08 by Dr. who noted the injection helped for 4 days. The examination was unchanged and a second injection was recommended and undertaken on 08/01/08.

The 08/08/08 visit with Dr. reported the injection helped the back pain but there was no change in numbness. The examination remained the same as the prior visits. Neurontin was prescribed. On 09/05/08 Dr. that the medication was denied and the claimant was getting worse. On examination there was a 4/5 motor deficit of the bilateral lower extremities and a sensory deficit in the left lower extremity. Discogram was recommended L3 through S1.

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

There are no clear-cut indications for surgical fusion in this case. As such, there is no clear indication for discography. As outlined in the ODG guidelines, discography has been significantly questioned as a preoperative indication for spinal fusion based on recent high-quality studies. Based on the information available, the reviewer finds that medical necessity does not exist for lumbar discogram L3-S1 62290.

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back-Discography 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](#)) 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).

While not recommended above, if a decision is made to use discography anyway, the following criteria should apply:

- 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

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)**