

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** AUGUST 7, 2009

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of proposed low pressure discogram at L3-4, L4-5 levels with control L2-3 and post CT (62290, 72295, 77003, 72132)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

### **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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724..4	62290, 72295, 77003, 72132		Prosp	1					Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-16 pages

Respondent records- a total of 97 pages of records received to include but not limited to:

TDI letter 4.13.09, 7.20.09; Request for an IRO forms; letter 6.16.09, 7.8.09; Orthopedic records 12.8.08-6.10.09; Myelogram and post myelogram Ct 5.8.09, 7.25.08; chest and Lumbar x-rays 5.8.09; MRI L-spine and x-rays 1.7.08, 2.19.09; Imaging report 1.5.09; Therapy note 5.21.09; operative report, Dr. 4.10.08; American Academy of Orthopedic Surgeons article, OKU: Spine 3,2006, Pg. 143-144, 83-84; American Academy of Orthopedic Knowledge Update, Spine; Pain Imaging: Discography pg 81-82; Texas Medical Board Bulletin, Fall 2007, vol.5#1; letter 7.7.09

Requestor records- a total of 146 pages of records received to include but not limited to: TDI letter 7.20.09; request IRO forms; American Academy of Orthopedic Surgeons article, OKU: Spine 3,2006, Pg. 143-144, 83-84; American Academy of Orthopedic Knowledge Update, Spine; Pain Imaging: Discography pg 81-82; Texas Medical Board Bulletin, Fall 2007, vol.5#1; Allied Therapy note 5.21.09; HBI2 report 5.13.09; Myelogram and post myelogram Ct 5.8.09, 7.25.08; chest and Lumbar x-rays 5.8.09; Request IRO forms on 4.13.09; letter 3.26.09, 4.6.09; ; Assessments for Clinical and Psychological use printout; MRI L-spine and x-rays 1.7.08, 2.19.09; Imaging report 1.5.09; MRI Rt Ankle 4.1.08; MRI RT knee and Rt shlder 1.7.08; Orthopedic records 10.28.08-5.29.09; TDI Letter 5.29.09, 6.3.09; DWC form 045A; AMR report 4.28.09; notes Dr. 1.22.08-8.7.08; Pain and Recovery Clinic note 11.8.07 ; notes Dr. 4.17.08-10.9.08

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The medical records presented for review begin with the progress notes of Dr. that outline multiple problems, the treatments rendered and the surgeries completed. There is a non-certification of a request for a lumbar discogram. This determination was appealed and again not certified.

Dr. noted in his May 21, 2009 progress notes that a Lumbar myelogram was completed on May 8, 2009 and demonstrated a previous lumbar laminectomy and a disc bulge at L4-5. One week later (May 13, 2009) psychosocial screening was completed noting that there were no psychiatric barriers to the procedure. It was also noted that the injured employee complained of pain and had a decreased range of motion to the lumbar spine. Dr. noted that there was a mechanical back pain of disc origin with a failed laminectomy syndrome. Dr. feels that a lumbar fusion procedure is needed in this case and that the only issue preventing this surgery is the lack of a discogram. Dr. outlines that this study is not a diagnostic one; rather this study is a pre-operative planning event. Dr. also feels that not doing this study would possibly result in loss of licensure.

MRI completed on May 8, 2009 noted canal stenosis at L2/3, minor disc bulge at L3/4 with canal stenosis, post laminectomy changes at L4/5 with ligamentum flavum hypertrophy and post laminectomy changes at L5/S1. Similar changes are noted on myelogram. Plain films noted osteophytic changes. None of the studies noted any instability of motion segment integrity loss as defined by the AMA Guides to the Evaluation of Permanent Impairment, 4th edition. EMG noted a L5/S1 radiculopathy.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

As noted in the Division mandated Official Disability Guidelines (Updated as recently as July 28, 2009) discography is "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](#))”

Thus, while there might be a need for discography after the determination that there is a need for lumbar fusion, as pointed out by Dr. , the ODG goes on to note “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.” However, the level of disc disease has been objectified with the objective studies already completed. Further “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](#)) Provocative discography is not recommended because its diagnostic accuracy remains uncertain, false-positives can occur in persons without low back pain, and its use has not been shown to improve clinical outcomes. ([Chou2, 2009](#)) 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.

Discography is Not Recommended in ODG.

Relative to the assertion that his license to practice medicine might be in jeopardy, please note that the event listed by the requesting provider was not adjudicated until 2007 and the actual events occurred years prior. Subsequent to that time, the standards of practice have changed and the indications for discography have been altered. This study will not advance the diagnosis or alter the treatment plan. Again Dr. feels that a lumbar fusion procedure is needed in this case and that the only issue preventing this surgery is the lack of a discogram. Dr. outlines that this study is not a diagnostic one; rather this study is a pre-operative planning event. There is no clear clinical indication for this assessment, as the requirements for the subsequent procedure a lumbar fusion in this workers compensation patient have not been met.

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

- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- XX OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (AMA Guides to the Evaluation of Permanent Impairment, 4th edition.)