



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 7-23-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Discogram and CT scan L3-L4, L4-L5 and L5-S1

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

American Board of Orthopaedic Surgery-Board Certified

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MD., office visits from 12-18-08 performed through 6-16-09.
- 1-15-09 EMG/NCS performed by , MD.
- 1-15-09 MRI of the lumbar spine.
- 2-13-09 Bilateral L4-L5 and L5-S1 facet joint block.
- 3-6-09 MD., office visit.
- 6-16-09, MS., progress report.
- 6-22-09 MD., performed a Utilization Review.
- 6-30-09 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

New office visit dated 12-18-08 performed by, MD., notes the claimant was injured back apparently on xx/xx/xx. He apparently had a lifting injury. He subsequently had the extensive chiropractic, which did not help. They did decompression, which only helped very temporarily. He had some physical therapy, some exercises, and stretching but that really did not change anything. He has had x-rays and MRI scanning. He has not had any other testing. He did see the psychologist because he had feelings of anger and worthlessness. He was on Lexapro for a while which worked for a while but then waned and he stopped that. He is really seeking a definitive cure if at all possible. He has good days and bad days. He is not able to do his old line of work. He is in school. On exam, the claimant has some tenderness at L5-S1 centrally and over the facet joints and also over the superior poles of the SI joints. Extension is more painful than flexion. Facet loading is questionably positive. He gets more central pain than the facet pain from that. Sitting root test is negative. Supine straight leg raising is negative. He has negative Lasegue test, negative Cram test, mid normal hip motion. Patrick maneuver on the right causes some central low back pain at 4-5 more than over the SI joints. He has decreased right Achilles tendon reflex and decreased EHL on the light. He has

decreased sensation involving the right posterolateral leg. Yeoman maneuver is positive bilaterally not for S1 pain but for pain up at L4-5. The evaluator ordered a new MRI. He has sort of a mixed bag. The evaluator explained to him that his symptomatology and his exam really do not fit squarely into one particular pattern. The evaluator thought he needs to salvage the path generator before we go any further. To that end, the evaluator ordered the MRI and EMGs of the right leg.

an EMG/NCS performed by, MD., was normal.

MRI of the lumbar spine dated 1-15-09 shows degenerative disc disease in the lumbar spine, greatest at the L4-L5 and L5-S1 levels.

Follow-up with Dr. dated 1-22-09 notes the claimant has EMG, which was negative. MRI showed some facet changes mid degenerative disk disease. The evaluator felt that he has mostly facet pain. Fortunately, he does not have any other complicating factors. He is still tender at 4-5 and 5-1. However, the facet joint extension is more painful than flexion. Facet loading is positive. Neurologically, he is grossly intact in both lower extremities. The evaluator ordered the facet injections based on the above. The evaluator gave the claimant some Norco 7.5 for his pain.

On 2-13-09, the claimant underwent bilateral L4-L5 and L5-S1 facet joint block.

Follow-up with Dr. dated 2-25-09 notes the claimant had facet injection. Unfortunately, he did not get anything from the anesthetic phase or long term. Basically, this rules out the, facets as the source of his problem. He has been through extensive conservative treatment and he is really any better. This is going on for a long time. The only thing left to do would be either to send him for the pain program or to get a surgical consultation to see if he is a candidate for a 2-level fusion. He did have decompression therapy before which gave him only temporary help, and he has with bending and stooping. The evaluator explained to him that he would probably need to have a discogram but we will leave that up to the surgeon to order that if need be. He does not take the Zanaflex as it gives him dry mouth. He is using the Hydrocodone. He had some leftover from the dentist and has not filled the one from me. We have told him again that he only needs to get medicine from one doctor which he will eventually fill the prescription from me and not get anymore from anywhere else. He remains off work. He is going to school.

Consultation provided by, MD., dated 3-6-09 notes the claimant is a xx-year-old gentleman who has had 3 years been out of his heavy labor job. He is off on Workmen's Compensation due to an injury when lifting at work 3 years ago. He has had conservative management including physical therapy and decompression therapy. He has only had short-term relief from the decompression therapy 1 to 2 weeks at a time. The PT really did not help. He saw Dr. in December 2008 who assessed him and wanted to rule out any facetogenic cause for the pain. He had facet injections at 4-5 and 5-1 and had zero relief not even that day from the injections. He has taken Hydrocodone for his pain. He also complains of some paresthesia in the right anterior thigh, especially with extended sitting. He states his back spasm is much worse than

sitting, driving in a car, leaning over washing dishes, or trying to help clean his kids and take care of them when he does part time. He has had no bowel and bladder problems associated with this. On exam, he is able to walk with a normal gait; heel and toe walk with no problems. He can flex forward with his hands to his anterior ankles. This is painful especially when he starts to try to get back into a standing position. Extension is slightly painful, but not nearly as much as flexion. He has no tenderness to his lumbar spine; no swelling, erythema, warmth, or skin changes. No skin changes to his lower legs. He has 2+ posterior tibial pulses. 5/5 strength in his hip flexors, quads, hamstrings, tibialis anterior, gastroesoleus, and EHL. Normal sensibility throughout. 2+ knee and ankle reflexes. No clonus bilaterally. There is no pain with internal and external rotation of the hips, and Fabere 4 bilaterally does cause him some pain, but this is not the pain he has been having. Overall diagnosis this time is internal disk derangement at L4-5 and L5-S1 with lumbar radicular syndrome (right anterior thigh paresthesia). The evaluator recommended evaluation by Dr. in the CoPE program, discogram at L3-L4, L4-L5 and L5-S1.

Follow up with Dr. dated 4-1-09 notes the claimant is having a lot of depressive symptomatology. He feels lonely. He is tearful and has anhedonia, apathy, anxiety, hopelessness, sleep disturbance. He has seen in Behavioral Medicine. He is not cleared for his discogram, pending some control of his depression. The claimant was given a prescription for Wellbutrin.

Follow-up with Dr. dated 5-14-09 notes the claimant has been on the Wellbutrin for a month now. He states he feels somewhat better, although when I questioned more specifically about anhedonia, melancholia, crying spells, apathy, etc. he still endorses a lot of those symptoms. He stated initially the Wellbutrin made him pretty angry. That is somewhat better but he is still having significant depression. The evaluator recommended the claimant go down to 1 a day on the Wellbutrin and stop that. The claimant will be given some Lexapro instead. He needs to follow up with in Behavioral Medicine before we can proceed with his discogram.

Follow-up with Dr. dated 6-16-09 notes the claimant is feeling better in terms of his psychological state. Things are stabilizing with kids. His family sees a big change in his affect. He has been more active. The Lexapro is working. He is off the Wellbutrin. He is to see today who is the LPC. If he is cleared by her, then we will go ahead and proceed with the discogram and he will need to follow up with Dr. after that or with me in 4 to 6 weeks depending.

Progress report provided by, MS., dated 6-16-09 for pre-surgical screening notes the claimant is clear for discogram and any subsequent surgery.

On 6-22-09, MD., performed a Utilization Review. The evaluator reported that ODG does not recommend the use of a discogram for patient with low back pain of any etiology. Even if used preoperatively to evaluate patient who might need surgery, it is found to have limited value. As such, the appropriateness, medical necessity, and anticipated benefits of this requested procedure is not sufficiently substantiated. The

request is not indicated. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for a discogram with CT at L3-S1 is not certified.

On 6-30-09, MD., performed a Utilization Review. The reviewer noted that as previously opined, ODG does not recommend the use of discogram for patients with low back pain of any etiology. ODG indicates discography may be justified if decision has already been made to do spinal fusion, and negative discogram could rule out need for fusion. However, there is no indication in submitted clinicals that a decision has been made to do spinal fusion. Based on the clinical information provided, the request is not indicated as medically necessary.

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

MEDICAL RECORDS REFLECT A CLAIMANT WITH CHRONIC LOW BACK PAIN. HE DOES NOT HAVE RADICULOPATHY BY PHYSICAL EXAM OR ELECTRODIAGNOSTIC TESTING. THE CLAIMANT HAS MULTILEVEL DEGENERATIVE DISC DISEASE. BASED ON THE MEDICAL RECORDS PROVIDED, THERE IS NO INDICATION FOR DISCOGRAM OR SURGICAL INTERVENTION. ODG DOES NOT SUPPORT PERFORMING DISCOGRAM AS PREOPERATIVE INDICATOR, NOR DOES THE CLAIMANT HAVE EXTENUATING CIRCUMSTANCES OR A CLINICAL PICTURE TO SUGGEST HE IS A SURGICAL CANDIDATE. THEREFORE, THE REQUEST FOR DISCOGRAM AND POST CT SCAN L3-L4, L4-L5 AND L5-S1 IS NOT ESTABLISHED AS MEDICALLY NECESSARY.

ODG-TWC, last update 7-16-09 Occupational Disorders of the 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) 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. 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

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)