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Notice of Independent Review Decision

DATE OF REVIEW: 6/10/09

IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Low Pressure Lumbar Discogram L3-L4, L4-L5, and L5-S1

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

Certified by the American Board of Orthopaedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective			Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.
Literature submitted: Texas Medical Board Bulletin (Fall 2007 Volume 5. No. 1), The Journal of Spine, orthopedic knowledge update, Chapter 9, on Pain Imaging:Discography
Physician notes/evaluations from 12/20/07 through 5/18/09
Psychosocial evaluation dated 2/17/09
Operative Report dated 11/20/08, 2/15/08
CMT/ROM report dated 5/18/09, 12/8/08
MRI report dated 1/10/08
X-ray reports dated 12/8/08, 1/7/08
Functional Capacity Evaluation report dated 3/23/09

Letter dated 3/2/09
Physical Therapy notes dated 1/23/08, 12/31/07
Official Disability Guidelines provided-ODG Treatment/Guidelines Low Back Problems, Discography

PATIENT CLINICAL HISTORY:

This claimant sustained an injury on xx/xx/xx when he stepped off a mat and slipped, causing him to fall forward, landing in a prone position. Later that evening, he developed pain in his low back and began medical care at that time.

On the 12/20/07 evaluation, the claimant complained of pain in his low back. He states the pain started a few days after he slipped on the date of injury. The pain was like an ache but not a sharp pain. He saw his usual treating provider and x-rays were done. He has been using hot packs and pain medicine. Past medical, social and surgical history was reviewed and was considered non-contributory. On examination he is well developed, well nourished and in no acute distress. Gait pattern was normal. Palpation revealed no significant tenderness and muscle spasm and motor strength was 5/5 bilaterally. Straight leg raise in the seated position was negative to 90 degrees. Faber test was negative and there were no upper neuro signs. Sensory examination was intact throughout the lower extremities. Range of motion of the hips, knees, and ankles were within normal limits. Pulses were 2+. X-ray was unremarkable. MRI scan had not been done. The claimant was diagnosed with lumbar strain. The patient was prescribed Motrin, Ultracet and physical therapy was prescribed.

On the evaluation of 01/07/08, the patient complained of constant pain in his low back. It was localized to the lumbosacral region and was typically worse with sitting, standing, bending, stooping, coughing and sneezing. He had some relief lying in a recliner. Past history was reviewed. Physical examination showed him to be alert and oriented x3. There was tenderness to palpation of the paraspinous musculature of the lumbosacral region and pain with range of motion. There was loss of lordosis. Straight leg raise was negative. DTRs were 2+ and symmetric. Motor examination was 5/5. Diagnosis was lumbar pain. Given the fact that he continued to be symptomatic, an MRI of the lumbar spine was ordered. It was also recommended that he start physical therapy. He was given a prescription for Lorcet, Flexeril, Feldene, and Ambien. Plan was to follow up after the MRI.

On 01/24/08 a follow up occurred. Physical examination was relatively unchanged. MRI was reviewed and the impression was bulge/protrusion at L5-S1. Plan was to continue oral anti-inflammatories, and a recommendation was made for a lumbar epidural steroid injection in conjunction with physical therapy. It is noted it had been 2 months since injury and the plan was to be more aggressive at this time. It is also noted that they are

going to attempt to break the current inflammatory cycle however if the back pain continues, lumbar discogram may be indicated.
On 02/21/08 follow up occurred. He had undergone lumbar epidural steroid injection on 02/15/08 with some mild improvement in his back but for the most part the symptoms were relatively unchanged. Straight leg raise at that time elicited back pain. The rest of the physical examination was unchanged. Impression was for protrusion at L5-S1 and discogenic back pain. The plan was to continue post injection rehabilitation, renew medications, and to try an additional lumbar ESI.

Follow up occurred on 03/25/08. At that time, he had reported some improvement although he was unsure whether it was related to the injection or decreased activity. The initial relief has worn off. He also complained of cramps in his legs with occasional numbness in his feet. The claimant stated he was in pain almost all the time. He has not been able to engage in normal recreational activities. Examination was relatively unchanged. Impression was unchanged from the previous impression. Discussion and plan was to proceed with the second lumbar ESI, post injection rehabilitation, and renew medications.

Follow up occurred on 07/08/08. This is almost 4 months from the last visit. At that time, the claimant was continuing to complain of low back pain. He was scheduled for a lumbar discogram on 07/11/08. He wanted medication refills at that time. He continued to have 7/10 back pain. There was no lower extremity pain. Examination showed tenderness to the lumbar spine with decreased range of motion. Straight leg raise elicits back pain. There was no strength loss or neurologic changes. Impression was discogenic back pain at L4-5 and L5-S1. Plan was to go for a second lumbar ESI on 07/11/08. Afterward, there was to be a short course of physical therapy.

Follow up occurred on 12/08/08. It is noted the patient had an injection on 11/20/08. The injection helped very little and he still had 8/10 back pain. It is also noted at this time that pain radiates to the left lower extremity. Examination showed positive straight leg raise on the left. There was weakness in the toe extensors on the left with difficulty with toe walking. He was able to walk on his heels without difficulty. There was diminished sensation along the left leg with paresthesias. Impression was mechanical back pain of discogenic origin at L4-5 and L5-S1. Plan was to recommend psychosocial screening per ODG. There was current noted failure of physical therapy and epidural injections.

Physician note of 02/17/09 noted that the results of the psychological screening showed the patient had no psychosocial barriers to recovery.

On 05/18/09 follow up occurred. At that time, the claimant still complained of significant 8/10 back pain. He had 2 lumbar ESIs with persistent pain. A designated doctor examination showed 0/8 Waddell's signs, indicating no symptom magnification.

Psychosocial screen was also mentioned. MRI showed bulging disc at 2 levels of the lumbar spine. It was noted that the patient had symptoms consistent with mechanical low back pain and the plan was to proceed with lumbar discogram.

Imaging studies: MRI of the lumbar spine was performed on 01/10/08. This showed posterior bulging disc at L4-5 and L5-S1. No evidence of fracture, dislocation, disc space narrowing, spondylolisthesis, epidural hematoma, or neoplastic process.

Functional capacity evaluation occurred on 03/23/09. The result showed the patient to currently be at a PDC of light which does not meet his self reported PDC of very heavy as a welding inspector. On the same day, a designated doctor examination occurred. At that time, the diagnosis was lumbar discogenic syndrome. It is noted the patient has reached maximum medical improvement as of that date and was assigned 5 percent whole person impairment rating. It was the opinion that the claimant was able to work without restrictions. Previous designated doctor examinations have occurred within the record but it is felt most significant to mention the most recent DD examination at this time.

The Reviewer noted the literature and guidelines provided:
1. The Journal of Spine, orthopedic knowledge update, Chapter 9, on Pain Imaging: Discography. The section under Lumbar Discography reads as follows:

"Clinical investigations of lumbar discography in asymptomatic subjects have revealed that discs that are morphologically normal by discography should not be painful. Coincidental annular tears may exist in normal (pain-free) subjects without pain provocation when injected discographically.

A highly specific MRI marker of high-intensity, concordant with discogenic pain, known as the lumbar disc high intensity zone (HIZ) has been described. A diagnosis of an HIZ must meet stringent criteria, including the use of high field MRI and T2-weighted images. (Fig.1)

Investigations with pressure-controlled discography have identified both mechanically-sensitive and chemically-sensitive lumbar disc pathologies that are significantly predictive of surgical and non surgical outcomes."

2. There is additional documentation included from the Texas State Medical Board Bulletin, Fall 2007, Volume 5, No. 1. In this bulletin, there is noted a physician who has undergone disciplinary action. This physician was required to complete a course in spinal surgery of at least 20 hours and a course of medical record keeping at least 10 hours and was made to pay an administrative penalty of $3000. The action was based on this physician not obtaining discography as part of the pre operative workup for 2 patients who underwent interbody fusion.

3. The ODG guidelines from the low back section are included as well. Under the section of Discography, it is noted that discography is not recommended. It has shown that a

discography 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 the latter patient type, the test itself was sometimes found to produce significant symptoms in non back pain controls more than a year after testing. The findings in discography have not been shown to consistently correlate well with the findings of high intensity zones on MRI. Discography may be justified if the decision has already been made to do a spinal fusion and negative discogram could rule out the need for a fusion. But a positive discogram itself would not allow a fusion. 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 a fusion on that disc. A positive discogram in and of itself would not justify fusion. **Discography is not recommended in ODG.** The patient selection criteria for discography if provider and payer agree to perform anyway: back pain for at least 3 months duration, failure of recommended conservative treatment including active physical therapy, MRI demonstrating 1 or more degenerated discs as well as 1 or more normal appearing discs to allow for internal control, satisfactory result from detailed psychological assessment, intended as a screen for surgery, briefed on potential risks and benefits from discography and surgery, single level testing, due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non certification.

The Reviewer cited an E-medicine article from MedScape and WebMD concerning discography. The URL is as follows: http://emedicine.medscape.com/article/1145703-overview

The Reviewer concluded that the use of discography remains controversial however the literature supports the use of discography in selective patients. Particular applications include patients with persistent pain in disc abnormalities suspected but non-invasive tests have not provided diagnostic information that needs to be correlated with clinical symptoms. Discography can also be helpful in the assessment of disc in patients when fusion is being considered and who pain remains after surgery. It is noted that this appears to be a well-written article and multiple studies were cited supporting the use of discogram as well as supporting the reasons not to use discogram. It contains a review of most of the well known studies on both sides of the argument.

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

After thorough review of the medical records and data presented, and thorough review of evidence based medicine guidelines, as well as using extensive clinical experience in the treatment of diseases of the lumbar spine, the determination at this time is to uphold the denial of lumbar discogram at this time. The Reviewer commented that there are other potent generators of back pain in these patients (degenerative and hypertrophy lumbar facets), and there is no current clinical evidence that there have been attempts to evaluate/treat facet related disease at this time, prior to intervention with a lumbar fusion surgery.

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)**