



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

DATE OF REVIEW: 6-15-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Discogram at L3, L4, L5 and S1 with and without contrast and post CT scan

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

American Board of Neurosurgery

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

- 1-5-07 MRI of the lumbar spine, left and right shoulder.
- 1-26-09 MRI of the cervical spine.
- 1-30-09, MD., office visit.
- 2-2-09 Functional Capacity Evaluation.
- 3-15-09 MD., performed a Designated Doctor Evaluation.
- 3-19-09, MD., office visit.
- 3-23-09 MD., amended report.
- 4-6-09, MD., office visit.
- 4-23-09, MD., office visit.
- 5-6-09, MD., Utilization Review.
- 5-19-09, MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

MRI of the lumbar spine dated 1-5-07 showed changes of spondylosis. There are small indentation demonstrated. No thecal sac at level of L4-L5 and L5--S1 which is compatible with degenerative spondylitic process. No evidence of injury to the annulus identified. No evidence of acute disc herniation. The claimant also had an MRI of the left and right shoulder, which showed tear of the rotator cuff of the left shoulder with impingement. There was minimal tear distal part supraspinatus tendon of the right shoulder.

MRI of the cervical spine dated 1-26-09 shows mild-to moderate degenerative disease with dico-osteophytic bulges at C4-C5 through C6-C7 with mild central canal and bilateral neural foraminal stenosis.

On 1-30-09, the claimant was evaluated by, MD. It is noted the claimant is seen for a follow up. The claimant continues with low back pain radiating to legs bilaterally more affected right leg with intermittent numbness of legs bilaterally more right than left. His pain level is at 8/10. He also complains of neck pain radiating to shoulders bilaterally with headaches. The claimant is currently taking Lortab 7.5mg QID, Amrix 2mg QID, Zoloft 15mg QD and he applies Lidoderm 5% patches BID. On exam, the claimant can walk and stand without impairment or assistance but with difficulty due to pain. Tandem

walking is not impaired either and deep tendon reflexes are equal and symmetrical on upper and lower extremities bilaterally. There is evidence of sensory loss on C5, C6, C7 and C8 on the left side. Positive straight leg raise test of 60 degrees on the right leg. There is no evidence of muscle atrophy. The evaluator recommended an epidural steroid injection and sacroiliac joint injection bilaterally.

A Functional Capacity Evaluation dated 2-2-09 notes the claimant is functioning at a Light to Medium PDL. His job required a Medium PDL.

On 3-15-09, MD., performed a Designated Doctor Evaluation. He certified the claimant had reached statutory MMI on 4-27-08 and awarded the claimant 29% whole person impairment. The evaluator noted that it appears that the claimant had progressed over a period of time since his injury of xx-xx-xx. However, on examination on March 16, 2009, it appears that claimant's condition has deteriorated since the previous examination on November 21, 2008. The impairment for the left shoulder as 13% combined with 8% for the right shoulder, 5% for the lumbar spine and 5% for the cervical spine. He noted that the claimant has spinal canal stenosis. Based on adjustment for effects or treatment or lack of treatment, claimant is assigned an additional 2% whole person Impairment per the Guides. The evaluator noted the claimant has to carry a cane to maintain balance and strength. For one reason or other, claimant has not had results as expected following his left shoulder surgery. He is now scared to Undergo any surgery including right shoulder surgery or any surgery for his lumbar or cervical Spine. Cervical pathology consists of disc pathology secondary to the protrusion of the cervical disc which has been complicated by the osteophyte complex noted in the MRI scan as well as the spinal canal stenosis in the lumbar spine for which claimant may eventually need surgery, though the claimant has decided against surgery based on the poor results of his left shoulder surgery. The claimant has decided that he would rather live a disabled life as he is today, rather than getting further disabled accompanied with constant pain and the need for constant pain medication for the rest of his life. Overall, claimant has few choices and for all the above reasons, he has reached MMI. In fact, claimant is under the care of a neurosurgeon who has contemplated surgery for the lumbar spine. Claimant have voiced confusion regarding further treatment, it's utility and Improvement value, if any, since the Injury occurred such a long time ago. The evaluator noted the claimant is not able to function in any gainful employment since he cannot sit for any significant length of time which is related to either the pain or combination of pain, loss of strength and an inability to perform the activities of daily living without assistance. Further treatment plan and options pursued by his neurosurgeon remain to be seen.

On 3-19-09, the claimant was evaluated by Dr. The claimant reported that the epidural steroid injection performed on 3-3-09 did not provide any relief. The claimant reported he was worse than before. The evaluator noted that he had exhausted all conservative treatment and it was sensible to consider surgical treatment. The claimant reported he would like to think about it.

On 3-23-09, Dr. provided an addendum to his prior report. He noted that in light of the surgery that claimant had performed on 5-30-08 which was after the MMI date; his impairment rating will change to 34% whole person impairment. Claimant is therefore now entitled to an additional 10% Impairment for the upper extremity for the left shoulder related surgery, thus changing the previous impairment rating assigned for the left Upper extremity. Upper extremity Impairment rating is calculated as follows: Left shoulder range of motion related Impairment Is 18% Upper extremity, 10% for the isolated clavicle resection, and 5% for the loss of strength. Therefore, 30% impairment rating is assigned for left upper extremity. This 30% according to page 20, table 3 of the AMA Guides, converts into 18% whole person Impairment. Therefore, the claimant's impairment rating for the left upper extremity changes from 13% to 18% whole person impairment for the left shoulder. This 18% Is combined with 9% for the right upper extremity, giving the claimant 25%, this combined with 5% impairment for the cervical spine gives claimant 29%, this combined with 5% Impairment for the lumbar spine gives claimant 33% Impairment. This 33% combined with 2% Impairment for issues discussed in the evaluators previous report gives the claimant 34% Impairment.

On 4-6-09, the claimant was evaluated by, MD. The claimant was seen for bilateral shoulder pain. The evaluator recommended bilateral shoulder cortisone injections.

Follow-up with Dr. on 4-23-09 notes the claimant continues with low back pain radiating to bilateral legs, more to the right. The claimant mentions that he has some neck discomfort but right now, he is concerned about the low back pain and leg pain. On last office visit, the evaluator explained him that it is sensible to consider two level lumbar fusion and instrumentation given the fact that he has failed every conservative treatment option. The claimant is not decided on the surgery and he will think about it.

On 5-6-09, MD., provided an adverse determination for the requested lumbar discogram with post CT scan. The evaluator noted that Discography Is not recommended In ODG guidelines as there is significant scientific evidence questioning the use of discography as a use of preoperative indication for either IDET or spinal fusion. The studies have shown that pain reproduction is inaccurate and of limited diagnostic value. It cannot be determined from the submitted documentation that the claimant is a candidate for lumbar fusion, and there is no indication from the submitted documentation that instability of the lumbar spine is present. The submitted MRI from 11/08 shows evidence of mild disc protrusions with no nerve root compression and no evidence of spondylosis, retrolisthesis, or severe facet arthropathy that would indicate instability in the lumbar spine. Additionally, the required psychological evaluation is not available for review. Based on lack of supporting evidence for requested procedure, medical necessity cannot be established at this time.

On 5-19-09, , MD., provided an adverse determination. The reviewer noted that the claimant is referred for an appeal request for lumbar CT and discogram with Interpretation. The claimant complains or weakness and radiating leg plain. MRI reports no evidence of nerve root impingement. No focal neurologic deficits are noted on physical exams. The denial is upheld, as ODG guidelines do not recommend

discography as a preoperative indicator for fusion. The rationale for discography is not clear for this patient as the submitted MRI clearly documents the degenerative pathology in the lumbar spine. Additionally the required psychological assessment was not available for review. Based on the submitted clinical documentation and ODG guidelines, medical necessity for the request is not established.

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

THE CLAIMANT HAS DONE POORLY SINCE HIS INJURY. HE CONTINUES TO COMPLAIN OF LOW BACK PAIN WITH RADICULAR PAIN. HOWEVER, PHYSICAL EXAMINATION FINDINGS HAVE NOT REVEALED EVIDENCE OF RADICULOPATHY. THE MRI OF THE LUMBAR SPINE HAS SHOWN SPONDYLITIC CHANGES. THERE IS NO DISC HERNIATION OR SPINAL STENOSIS NOTED. THERE HAS BEEN NO PSYCHOLOGICAL EVALUATION IN THIS CLAIMANT THAT HAS FAILED ALL FORMS OF TREATMENT. BASED ON THE MEDICAL RECORDS PROVIDED, THERE IS NO INDICATION FOR PERFORMING A DISCOGRAM, AS THIS CLAIMANT DOES NOT APPEAR TO BE A SURGICAL CANDIDATE. THERE IS NOT ENOUGH EVIDENCE THAT ANY LUMBAR SURGERY IS WARRANTED AT THIS TIME. IT APPEARS THE CLAIMANT IS EXPERIENCING RADICULAR PAIN AND NOT DISCOGENIC PAIN. ADDITIONALLY, CURRENT EVIDENCE BASED MEDICINE NOTES THAT THE RESULTS OF DISCOGRAPHY AS A PREOPERATIVE INDICATION FOR IDET OR SPINAL FUSION ARE QUESTIONABLE. THEREFORE, NON-CERTIFICATION IS PROVIDED.

ODG-TWC, last update 5-28-09 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)