



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: March 25, 2009

IRO Case #:

Description of the services in dispute:

Out patient discography at L3-4, L4-5, L5-S1 and post CT at the same levels denied as not medically necessary.

A description of the qualifications for each physician or other health care provider who reviewed the decision:

The physician who provided this review is board certified by the American Board of Physical Medicine and Rehabilitation. This reviewer has been in active practice since 2005.

Review Outcome:

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

Upheld.

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 request for lumbar discography at L3/4, L4/5, and L5/S1 and post CT at the same levels is not medically necessary.

Information provided to the IRO for review:

IRO request forms 3/11/09 5 pages

Follow up office visit notes 10/2/08, 11/05/08, 12/5/08, 2/5/09 8 pages

Procedure note 10/22/08 2 pages

Procedure request form 2/5/09 1 page
Fax coversheet requesting preauthorization 2/9/09, 2/16/09 2 pages

Records from the Insurance Company:

Employers First Report of Injury undated 1 page
Work Hardening/Pain Management Time Sheet 11/11/08–11/26/08 2 pages
Physician Activity Status Report 12/27/07 2 pages
PT notes 12/27/07, 12/28/07, 12/31/07, 1/2/08, 1/4/08, 1/9/08, 1/18/08 31 pages
Referral from 1/18/08 2 pages
Email regarding the patient 1/23/08 1 page
MRI report 1/24/08 3 pages
Physical Activity Status report 1/28/08 1 page
Progress notes 1/28/08, 8/5/08 5 pages
Physical Therapy referral form 1/31/08 1 page
Work Status Reports 1/31/08, 2/21/08, 3/27/08, 5/13/08, 6/12/08, 7/14/08, 9/15/08, 9/19/08
9 pages
Office visit notes 1/31/08, 2/21/08, 3/27/08, 6/12/08, 7/14/08 8 pages
Treatment encounter notes 2/4/08, 2/20/08, 2/22/08, 3/5/08, 3/7/08, 2/27/08, 2/25/08,
2/15/08, 3/12/08, 3/17/08, 3/28/08, 5/21/08, 7/8/08 15 pages
Plan of treatment 2/12/08 2 pages
Pain consultants clinical assessment 2/26/08 4 pages
Initial Behavioral Medical Evaluation 2/26/08 2 pages
Precision Pain consultants follow up notes 3/10/08, 4/4/08, 4/22/08, 5/12/08, 5/22/08, 10/2/08,
12/05/08, 3/5/09 16 pages
Fax confirmation sheet re wage information 3/11/08 1 page
Behavioral Medical Service Reports 2/26/08, 5/12/08 3 pages
Pain consultants radiological review 2/26/08 1 page
Utilization review outcome letters (Forte) 2/13/08, 3/18/08, 4/15/08, 5/19/08, 5/20/08, 6/2/08,
10/9/08, 10/30/08, 11/19/08, 12/8/08, 12/31/08, 2/5/09, 2/16/09, 2/23/09, 3/5/08, 3/19/08,
5/2/08, 2/13/09 42 pages
Authorization for requested services 3/18/08 1 page
Pain consultants procedure report (facet injection) 3/21/08 2 pages
EMG/NCV report 4/15/08 2 pages
Beck's Questionnaire 5/2/08, 12/3/08 8 pages
Report of Medical Evaluation 5/2/08 1 page
Lab report 5/12/08 2 pages
Designated Doctor Report 5/13/08, 12/11/08 8 pages
Plan of Treatment 5/28/08 1 page
Chart note 6/12/08 1 page

Notice of Representation or Withdrawal of Representation 6/19/08 1 page
Workers Comp Verification and Questionnaire Form 5/14/08 1 page
Radiology report 6/21/08 6 pages
Discharge summary 6/21/08 3 pages
Chart note 6/21/08 4 pages
Lab report 6/25/08 4 pages
Physician Progress Notes 6/22/08–6/24/08 2 pages
Admission History and Physical 6/21/08 1 page
CT Lumbar spine with Myelogram report 7/2/08 2 pages
Nurses notes 7/2/08 2 pages
office notes 9/15/08 3 pages
Prescription for injections 9/15/08 1 page
Authorization for requested Services 10/8/08 1 page
Patient demographic form 10/14/08 1 page
Workers Comp and auto accident information undated 1 page
Psychological Assessment 10/15/08 4 pages
Authorization request for continued services 10/15/08 1 page
Pain Therapy Initial Evaluation 10/15/08 2 pages
Precision Pain consultants procedure report (TFESI) 10/22/08 2 pages
Request for precertification pain management program 10/24/08, 12/2/08 3 pages
notes 11/4/08, 11/7/08, 11/11/08, 11/12/08, 11/17/08, 11/18/08,
11/21/08, 11/24/08, 11/25/08, 12 pages
Peer Review report 11/4/08 18 pages
Pain Management program initial evaluation report 11/12/08 2 pages
Letter from 11/20/08 1 page
Notice of Disputed issue and refusal to pay benefits 11/20/08 1 page
PT progress report 11/25/08 1 page
Pain consultants procedure report (TFESI) 11/25/08 2 pages
Report of Medical Evaluation 12/3/08 1 page
Email regarding incoming and outgoing phone calls 2/2/09 1 page
Letter regarding impairment rating testing 2/10/09 1 page
Acknowledgment of reconsideration request 2/17/09 3 pages
Peer Review report 3/14/09 21 pages
List of patient's medications undated 2 pages

ODG Guidelines were not submitted for review

Patient clinical history [summary]:

The patient is a male who, according to the employer's first report of injury or illness, injured himself on xx/xx/xx when he slipped on some tile at work and injured his right knee and lumbar area.

On xx/xx/xx, the patient was seen at Medical Center . At that time he complained of pain in his right knee and low back. His past medical history included hypertension, depression, GERD, and insomnia. His past surgical history was negative. Medications include Atenolol, Sertraline, Ambien, and Nexium. Physical examination showed he was alert and oriented in no acute distress. The patient has tenderness to palpation in the right and left paraspinal muscles to T6 and paralumbar region to S1. Appearance noted a slight left lateral shift. There was limited right and left lateral rotation. Deep tendon reflexes were normal. Straight leg raise was positive on the right. Strength was 4/5 in flexion/extension. McMurray's was positive. X-rays of the right knee were normal. X-rays of the lumbar spine showed slight curvature. Assessment was 1) back pain; 2) knee pain. Plan was for crutches, splints, and medications. He was to be at physical therapy 3 x week up to 6 visits. He was to be off work today and tomorrow, and start modified work.

The patient had 5 physical therapy visits and returned for follow-up on 01/09/08. At that time he had no paresthesias, no radicular symptoms, no lower extremity weakness, and no changes in bowel or bladder control function. Physical examination remained unchanged except some tenderness to palpation in the lateral less than medial facet joint line. There was no swelling. Diagnosis continued to be the same. The plan was to continue therapy, precautions as far as medications are concerned, stay off work due to pain, and MRI right knee to rule out internal derangement.

On 01/24/08, the patient had MRI of the lumbar spine. It showed a broad degenerative annular bulge and disc at T12-L1 and L5-S1. There was no selective nerve root involvement. There was no focal disc herniation. MRI of the right knee and bilateral hips were negative.

On 01/28/08, the patient had follow-up and was still symptomatic. The MRI's were essentially negative, although the patient was still in significant pain. The plan was to refer to an orthopedic specialist.

On 01/31/08 at Orthopedics, saw the patient. The neurologic examination showed numbness and tingling. Straight leg raise was negative bilaterally. Deep tendon reflexes were intact. Normal sensation in dermatomes was noted. Internal rotation of the hips caused buttock pain but no groin pain. The claimant had good heel toe walk. Normal Romberg was reported. Right knee examination was essentially negative. The impression was low back pain with annular tear at L5-S1,

pain in the hips, and pain in the right knee. The treatment plan was to continue physical therapy with McKenzie exercises and continue Motrin 800 mg.

On 02/26/08, the patient began being seen at Pain Consultants. Chief complaints at that time were lumbosacral and bilateral hip pain. It was constant stabbing, burning, and aggravated with prolonged standing positions, and alleviated by lying down. Intermittent pain radiating down the bilateral buttocks, posterior midline thighs, and lower legs and stopping at the ankles was noted. The pain is sharp in quality. Associated spasms and occasional numbness was noted. Examination of the lumbar spine shows limited range of motion with some positive impingement signs at the L5 junction, mid lumbar, and upper lumbar region, as well as tenderness. Faber was positive bilaterally. Impression was axial lumbosacral pain with extension. Radicular pain in S1 pattern was noted. The patient was prescribed Robaxin and Darvocet N-100. The patient continued frequent follow-ups with Dr. and pain consultants.

On 04/15/08, the patient had EMG/NCV testing performed. The result showed normal EMG testing of the bilateral lower extremities. He continued follow-up with Dr. and pain management after testing.

On 06/21/08, the patient was admitted to the hospital for intractable back pain. He was treated with pain management, pain medications, and sent home on 06/25/08. The assessment was intractable back pain with no neurological deficits. He had a CT scheduled shortly thereafter. The plan was to continue to control pain.

On 07/02/08, the claimant had a CT myelogram of the lumbar spine that showed a small midline L5-S1 subligamentous disc protrusion, with chronic superior endplate deformity of L1 causing mild central canal stenosis.

An MRI was performed just prior to that on 06/21/08 as part of the admission that showed a small central disc protrusion L5-S1. There was a subligamentous herniation noted at T12-L1.

The patient continued close medical follow-up with Dr. after this hospitalization. On 10/02/08, the patient saw Dr. for a spine evaluation. Surgery was not recommended at that time. He recommended epidural steroid injections and facet joint injections. Physical examination was essentially unchanged. Straight leg raise was positive on the right with right lower extremity pain and possible lumbar radiculitis in an L5 pattern.

It was also noted at this time that the patient has seen behavioral psych for 2 visits thus far and was diagnosed with depression related to the injury.

On 11/07/07, the claimant began treatment at Pain Therapy for physical therapy. The patient had 8 additional physical therapy visits. On 11/25/08, he was seen back at Pain Consultants for a right lumbar transforaminal epidural steroid injection.

The patient continued close medical follow-up with pain management and despite temporary relief from lumbar epidural steroid injections, he continued to be symptomatic through the 03/09 timeframe. A discogram was ordered at L3-4, L4-5 and L5-S1.

Dr. initially reviewed the request on 02/11/09. The reviewer non-certified the request and notes that the patient was injured xxx ago. The rationale is not clearly delineated, but appears to be secondary to objective findings of radiculopathy and current participation in a pain management program.

Dr. reviewed the request on appeal on 02/16/09. The reviewer upholds the previous denial and non-certifies the request. The reviewer opines that the patient has participated in a chronic pain management program and previously had a psychiatric evaluation, which reports major depression. The patient is reported to have had a recent death in the family and reported depression. The patient is not reported to be a surgical candidate. The reviewer upholds the previous denial

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision:

Items in dispute: Out patient discography at L3-4, L4-5, L5-S1 and post CT at the same levels.

There is agreement with the previous reviewers that the request for lumbar discography at L3/4, L4/5, and L5/S1 is not medically necessary. The submitted clinical records indicate that the patient sustained work related injuries to the low back and knee as the result of going underneath a construction tape/barrier. The patient was initially diagnosed with a lumbar strain. The patient has received extensive conservative treatment and was previously evaluated by a surgeon who reported that the patient is not a surgical candidate. He subsequently received extensive conservative care and interventional procedures without improvement. The patient was later referred for a chronic pain management program (CPMP), which is a tertiary level program. The patient has had psychiatric evaluations and subsequent treatment with a diagnosis of major depressive disorder and anxiety. The patient has also recently suffered a death in his family exacerbating his depression.

Current evidenced based guidelines do not support the performance of discography as an indication for surgery and the patient is previously reported to not be a surgical candidate. The ODG requires that all patients who are recommended to undergo discography have a preoperative psychiatric evaluation to address any confounding issues that may skew the patient's response during this very

controversial diagnostic test. Given the patient's history of comorbid psychiatric issues, there is not a reasonable expectation that the patient will provide valid responses during provocation, which is why discography is not to be used as an indication for surgery, and should only be performed to exclude levels of treatment when surgery is indicated.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Discography is Not Recommended in ODG.

Patient selection criteria for Discography if provider & payor agree to perform anyway:

- Back pain of at least 3 months duration
- Failure of recommended conservative treatment including active physical therapy
- 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)
- 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)
- 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.
- Briefed on potential risks and benefits from discography and surgery
- Single level testing (with control) (Colorado, 2001)
- Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification