

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/11/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Low Pressure Lumbar Discogram at the L5-S1 Level with Post Discogram CT Scan

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Operative report, 01/02/08
Office notes, Dr., 05/21/09, 07/21/09, 09/29/09, 11/10/09
Electromyography studies, 06/11/09
MRI Lumbar Spine, 06/16/09
X-rays lumbar spine, 06/16/09
DDE, Dr., 07/13/09
Procedure Note, 09/11/09
X-rays lumbar spine, Undated
Psychosocial screening, Dr., 10/20/09
Request, 11/18/09
Office note, Dr., 12/14/09
Adverse Determination Letter, Dr., 12/18/09
Adverse Determination Letter, 01/15/10
Numerous Articles on Discography
Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, (i.e. Low Back-Discography)

PATIENT CLINICAL HISTORY SUMMARY

This male claimant developed back pain radiating to the leg on xx/xx/xx while moving furniture. On 08/27/08 he underwent an L5-S1 lumbar microdiscectomy. Postoperatively his back pain continued and his right leg pain was better for approximately 2 months, but then returned. Dr. saw the claimant on 05/21/09 for complaints of back pain radiating to the right leg with numbness and tingling to the right foot and left leg pain. The examination showed asymmetric motor strength, slightly weaker right flexor hallucis longus and weak bilateral extensor hallucis longus and left foot evor. Straight leg raise was positive bilaterally for leg symptoms, greater on the right and Lasègue and Bragard's were positive. Recurrent radiculopathy and possible recurrent herniated nucleus pulposus were diagnosed. EMG studies were done on 06/11/09, but no summary or conclusion was provided. A lumbar

MRI on 06/16/09 showed mild contrast enhancement in the posterior element at L5-S1 from previous surgery and a 3 millimeter broad-based disc herniation at L5-S1 with disc space narrowing. There was a 1.5 millimeter broad-based disc bulge with stenosis of the central canal and lateral recesses at L4-5. Lumbar x-rays on 06/16/09 showed a 1.5 millimeter broad-based disc bulge with short pedicles at L4-5 with thickening of the ligamentum flavum causing slight central canal stenosis and short pedicles causing slight lateral recess stenosis bilaterally. At L5-S1 was a 3 millimeter broad based central disc herniation compressing upon the thecal sac. There was marked stenosis of the lateral recess on the right side; moderate stenosis of the lateral recess is seen on the left and slight neural foraminal encroachment bilaterally.

Dr. performed a designated doctor evaluation on 07/13/09 stating the claimant had 24 sessions of therapy and a home exercise program postoperatively. The claimant was declared at maximum medical improvement and assigned a 10 percent impairment rating and advised to return to work light duty. Dr. re-evaluated the claimant on 07/21/09 for significant back pain radiating to the right leg with a ratio of 50/50 or 60/40. The examination showed a positive straight leg raise on the right, diminished sensation along the right S1 distribution and diminished reflex in the right Achilles. Dr. felt that the EMG was more or less normal and diagnosed the claimant with a herniated disc at L5-S1 and right S1 radiculopathy. Postoperative therapy, oral anti-inflammatories and an epidural steroid injection were recommended. On 09/11/09 lumbar epidural steroid injection and lysis of adhesions was performed. This resulted in 70 percent relief for about 5 days. At the 09/29/09 follow up continued back pain radiating down the left lower extremity was noted. There was tenderness in the right lower lumbar region, decreased flexion/extension limited by pain, positive straight leg raise on the right, decreased sensation along the right S1 distribution and diminished right Achilles reflex. A psychosocial evaluation on 10/29/09 by Dr. found no psychosocial barriers to recovery and a good candidate for any treatments that would help him. Dr. 's11/10/09 examination noted decreased lumbar motion with tenderness and palpable spasms, back pain with straight leg raise and intact strength, sensation and reflexes. Failed laminectomy syndrome with mechanical discogenic back pain was diagnosed and a lumbar fusion at L5-S1 and preoperative lumbar discogram were recommended. This was denied by 12/18/09 and 01/15/10 reviews and is currently under dispute.

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

Discography is not recommended in ODG. One of the concerns regarding the indication for discography is the evidence that there is a high rate of positive discograms following previous lumbar surgery. Other concerns are psychosocial variables that can have a confounding effect. The evidence-based guidelines do suggest that in cases where individuals do meet criteria for fusion surgery that discography can be an option in terms of selecting proposed levels. The indication for fusion is based on structural instability of the spine or progressive neurologic deficit, tumor, or infection. None of these indications are in evidence in this patient's case. When giving consideration to the ODG which does not support discography routinely and no other compelling indications for discography in this case, the reviewer finds that medical necessity does not exist for 1 Low Pressure Lumbar Discogram at the L5-S1 Level with Post Discogram CT Scan .

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, (i.e. Low Back-Discography

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) 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)

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-AMERICA 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)