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Notice of Independent Review Decision

DATE OF REVIEW: 12/29/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Lumbar Discogram L4-5 with Post CT scan

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

Texas Board Certified Neurosurgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. IRO coversheet
2. Back and Neck Institute, M.D.; PA, 05/02/05 thru 10/30/09
3. Office notes Hospital , 05/09/05
4. MRI of the lumbar spine dated 07/29/06
5. MRI of the right shoulder dated 09/22/06
6. Multiple nerve block and SI joint injection procedure notes 01/04/07 thru 01/30/07
7. MRI of the thoracic spine dated 08/02/07
8. MRI pelvis without contrast dated 09/06/07
9. MRI of the lumbar spine dated 01/31/08
10. Operative report for L2-3 laminectomy with re-do hemilaminectomy and left L4-5 hemilaminectomy, 04/17/08 thru 08/26/08
11. Operative report for transforaminal epidural steroid injections, 08/26/08
12. MRI of the lumbar spine dated 02/11/09
13. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male with a history of previous back injury and compensable injury consisting of lumbar spine degenerative disc disease who has since 2005 according to the medical records been followed by M.D., for treatment of his lumbar symptoms. He initially saw Dr. on 05/02/05 with a diagnosis of lumbar radiculopathy and lumbago. He had an initial L4-L5 right sided endoscopic decompression on 09/20/05. He had shown great improvement after this surgery and was continued to be followed by Dr. after that.

Sometime around the May, 2006 timeframe, according to the medical records the employee had been returned to work but was reporting problems with morning back pain as well as pain that increases after a regular work day. It was centrally located and exacerbated with motion.

The employee saw Dr. on 05/30/06. Physical examination at that time showed guarded motion in the lumbar spine that exacerbates with extension and left rotation. Lower extremities were neuromuscularly intact as well as deep tendon reflexes with negative straight leg raise bilaterally. Assessment was lumbago and previously known herniated disc at L3-L4. The plan was to request lumbar facet blocks to try to help his low back pain.

One month following, the employee continued to be increasingly symptomatic with pain at 7/10. Although he was scheduled for lumbar facet blocks, it was noted that the employee was having increased pain with radiculopathy to the lower extremity. It was also noted on the visit of 06/16/06 the employee notes he injured himself on 06/01 when a bus door opened and he almost fell down. He had to grab the handle to prevent from falling and jarred his back.

On 01/04/07, the employee had a coccygeal nerve block for tailbone pain and on 01/30/2007 had bilateral SI joint injections for sacroiliitis. There were no reported complications from these injections. Repeat lumbar MRI was performed within this timeframe that showed spinal canal stenosis at L3-L4, a right sided L4-L5 mild disc bulge and mild facet arthropathy at L3-L4 and L4-L5. Additional procedures at this time included treatment of internal derangement of the right shoulder which consisted of shoulder arthroscopy with labral debridement and open acromioplasty with rotator cuff repair on the right.

It was noted in the follow up office visit on 02/14/07, the employee did receive significant relief from the injections that were given. He was doing stretching and shrinking exercises at home and was tolerating these well.

On follow-up visit 03/09/07 with Dr., it was noted the employee had initial great symptomatic relief from the injections; however, he reported that symptoms had since returned. Pain was at the same level as it was prior to the injections, being 7/10. The plan was to proceed with additional MRI scanning to evaluation for additional pathology.

MRI of the thoracic spine was obtained on 08/02/07 that was negative for any significant pathology.

There were initial issues with approval of the pelvic MRI, but apparently one was eventually done on 09/06/07. This showed mild diffuse cartilage loss in the hips bilaterally without full thickness cartilage defects or intra-articular bodies. There was sigmoid diverticulosis. There was multiple lower lumbar spondylosis noted. Mild thickening of the urinary bladder wall was noted.

Over the next several months, the employee continued to have on and off symptoms of radiculopathy and low back pain. He was treated with additional epidural steroid injections and conservative treatment measures. He had a repeat MRI on 01/31/2008 of the lumbar spine that showed progression of central stenosis at L3-4 and to a lesser extent at L4-5 and apparent post right L4-5 hemilaminectomy.

Ultimately on 08/26/08 the employee was taken back to the operating room for redo right hemilaminectomy at L4-L5 with a left L4-L5 hemilaminectomy and L2 and L3 laminectomy. There were no noted operative complications.

Postoperative follow-up occurred on 09/08/08. He was doing well and no longer taking narcotic medication. The employee had also stopped muscle relaxants. He was noted to be very proactive and continued to improve. He ambulated regularly and was using the proper body mechanics.

The employee returned for a six week follow-up on 10/08/08 and ten week follow-up on 11/03/08. There was a considerable decrease in the amount of pain as well as the amount of pain medication utilization. The plan was to begin physical therapy to maximize his recovery.

Follow-up visit 12/15/08, the employee was returning after attending physical therapy. He had good range of motion and adequate strength. He did report sharp lumbar pain that radiated laterally through the lumbosacral region and escalating up to a level of 8/10 with pulling sensation and pain along the left medial thigh. Physical examination showed him to sit with a left outstretched leg to control his symptoms. He stood from a sitting position in a guarded fashion. Lumbar spine showed guarded movements that quickly exacerbated on extension and rotation and tilt. Lower extremities showed global decreased sensation throughout the left entire leg. Quick fatigue of the left hip flexors. Flexion/extension views of the lumbar spine demonstrated decreased disc height at L5-

S1 with Grade 1 spondylolisthesis at L5-S1. There also appeared to be a pars articular defect at L4-L5. The remainder of the examination appeared intact. Assessment was lumbar spine stenosis, lumbar radiculopathy, lumbago, L4-L5 pars defect, L5-S1 Grade 1 spondylolisthesis. Plan was to obtain a CT to better address the pars defect and follow-up afterwards.

A CT of the lumbar spine was performed on 01/07/09. This showed previous L3-L4, L4-L5 laminectomy changes with adequate capacity in the canal. There was facet arthrosis and ligamentum flavum hypertrophy noted with disc bulging and disc calcification producing moderate to lower neuroforaminal impingement bilaterally. L2-L3 noted a bulging calcified disc producing moderate lower neuroforaminal impingement bilaterally. There was no noted pars defect on CT report.

Continued follow-up visits occurred in January, February, March, April, and May of 2009, with subsequent MRI of the lumbar spine occurring on 02/11/09. This showed L3-L4 laminectomy changes with osteophytic ridging and disc bulging producing moderately severe bilateral foraminal stenosis with no focal disc protrusion seen. At L4-L5 there were laminectomy changes with some clumping of the neural structures suggesting chronic arachnoiditis. There was also enhancing epidural fibrosis seen at the operated levels. Plan was to proceed with approval for a lumbar discogram based on the final office visit on 10/30/09. It was opined that the discogram was required to identify whether or not his symptoms are discogenic in nature.

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

Based on thorough review of the contained medical records, as well as extensive experience as a neurosurgeon with board certification in the treatment of spine and spinal related conditions, the request for lumbar discogram L4-5 and post CT scan is not recommended at this time. When reviewing the current ***Official Disability Guidelines*** Treatment of Worker's Compensation Patients 2010 Edition, Online Edition, discography is not recommended in ***Official Disability Guidelines***.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. ***Official Disability Guidelines***, Low Back chapter, Online Version
2. Carragee EJ, Tanner CM, Khurana S, Hayward C, Welsh J, Date E, Truong T, Rossi M, Hagle C, The rates of false-positive lumbar discography in select patients without low back symptoms, *Spine* 2000 Jun 1;25(11):1373-80; discussion 1381