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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient lumbar discogram at L3-4, L4-5, L5-S1 levels

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:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines Treatment in Worker's Comp 2010 Updates
ER Report, 09/21/08
X-rays pelvis, 09/21/08
X-rays right knee, 09/21/08
Office notes, Dr, 09/24/08, 10/01/08, 10/16/08, 10/21/08, 10/30/08, 12/10/08, 12/22/08, 01/20/09, 02/10/09, 03/10/09, 04/08/09,
MRI Right Hip, 10/01/08
X-rays sacrum/coccyx, 10/01/08
Office note, Unknown provider, 10/24/08, 11/12/08, 02/11/09, 09/11/09, 03/17/10
MRI Lumbar Spine w/o contrast, 11/08/08
Operative report, 12/03/08
DDE, Dr., 12/19/08
Record review, Dr., 01/12/09
Office note, PA, 06/22/09, 07/22/09, 09/24/09, 10/26/09, 11/23/09, 12/28/09, 01/28/10, 03/01/10, 04/05/10, 05/06/10
Electrodiagnostic study, 07/08/09
Office notes, Dr, 08/05/09, 09/02/09
Office note, PAC, 09/28/09
Office note, PAC, 10/26/09, 11/23/09, 12/21/09, 01/19/10, 02/16/10, 03/16/10, 04/13/10
Procedure note, 12/23/09
Initial Behavioral Medical Evaluation, Dr., 01/19/10
Medical Evaluation, Dr., 01/20/10
Urine Drug Screen, 02/16/10

Prescription, 03/17/10
Request, 03/22/10, 03/26/10
Review, 04/01/10, 04/27/10
Physical Therapy Initial Evaluation and Plan of Care, 12/29/09
Behavioral Medical Service Report, 01/19/10
Daily PT Notes, 01/25/10, 01/27/10
Discharge PT Summary, 01/27/10
Request, 03/31/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a twisting injury to her right back while lifting a heavy patient on xx/xx/xx. A few weeks prior she had also sustained direct trauma to the right knee and tripped and did a split injuring her right hip and pelvis. The claimant was seen in the emergency room on xx/xx/xx post injury that day. She had pain on weight bearing. She was noted to be a smoker. The examination showed mild soft tissue tenderness right lower thoracic paraspinous region and right upper lumbar paraspinous region, mildly limited lumbar motion, mild bony tenderness of the right hip and right knee, had a limping gait. There was no motor or sensory deficit. X-rays of the pelvis that day were normal. X-rays of the right knee that day showed no acute appearing fracture or dislocation.

Dr. saw the claimant on 09/24/08 for low back pain without radicular symptoms, but dysesthesias of both feet attributable to diabetes. It was noted that she had also fallen at work in xx/xx/xx and injured her right hip and struck a chair with her right knee in xx/xx. Hoover testing showed the claimant rose the right leg with effort and the left leg without effort. Straight leg raise was negative bilaterally, but elicited low back pain on the right. There was right sided lumbar paraspinal muscle spasming which was tender. She was to return to work with restrictions. The 10/01/08 examination showed pain with axial compression, Hoover testing showed she raised both legs without effort, but could only raise her right leg approximately 45 degrees. She required assistance in sitting up from supine, had a negative straight leg raise bilaterally, but had pain in the injured right knee and right hip. The examination was otherwise unchanged. Therapy and over the counter Tylenol were recommended. An MRI of the right hip on 10/01/08 was normal. There was a rounded area of signal alteration in the right sacral ala which appeared consistent with fatty marrow. There was an incidental small cyst of the anterior left femoral head and free pelvic fluid. X-rays of the sacrum and coccyx on 10/01/08 were normal. On 10/16/08 she reported severe pain radiating down the right leg without dysesthesias. On examination she moved easily, active straight leg raise elicited right low back pain. She had no pain with axial compression, she could raise each leg up off the table without effort, had pain of the medial right thigh with straight leg raise, sat up from supine without assistance and had mild spasming of the right lumbar paraspinal muscle which was non tender. On 10/21/08 she reported low back and right groin pain. She reported right groin pain with Patrick test. The examination was otherwise normal.

The claimant was seen by an unknown physician on 10/24/08 reporting 90 percent back pain and 10 percent right leg pain. She was noted to be a diabetic and a smoker. There was diffuse lumbar spinous process tenderness, decreased lumbar motion, negative supine and seated straight leg raise. Strength, reflexes and sensation were normal. Dr. re-evaluated the claimant on 10/30/08 and noted improving back pain with occasional radiation down into the right knee. Slump testing caused mild upper back pain. Hoover testing showed the claimant raise the right leg to only about 45 degrees despite an absence of effort. She was able to raise the left leg without effort and sat from supine without assistance, but with difficulty. A lumbar MRI on 11/08/08 demonstrated mild focal central and left paracentral disk protrusion at L4-5 with associated annular tear. The claimant was seen again by an unknown doctor on 11/12/08 noting aggravation of symptoms with coughing/sneezing, etc. The examination showed moderate L5 lumbar spinous process tenderness, mild bilateral lumbar paravertebral muscle spasm, decreased flexion, negative sitting and supine straight leg raise, symmetric reflexes and intact sensation. On 12/03/08 left L5 transforaminal nerve root injection and

right L5 transforaminal nerve root injection were administered. Dr. re-evaluated the claimant on 12/10/08 noting not much change post injection. The examination was normal. She was released to work without restriction. Dr. reportedly had taken her off work completely and the orthopedic surgeon treating her hip had her off work until February and her temporary job assignment was over.

Dr. performed a designated doctor evaluation on 12/19/08 and noted her complaints of low back and left leg pain with numbness. The examination showed her to walk with a limp, unable to squat, was able to stand on one leg and heel/toe walk with difficulty, had tenderness to palpation and spasm of the paraspinal muscles bilaterally, pain with axial compression of the lumbosacral spine, trigger points with muscle spasms with tenderness to palpation of the lumbar spine, burning and pain with tenderness to palpation of the sacrum and coccyx, bilateral pain, greater on the left of the sciatic notches with tenderness to palpation, pain with tenderness to palpation of the thighs and calves. Straight leg raise in supine was 40 degrees bilaterally and caused numbness on the right. Seated straight leg raise was negative bilaterally. Hoover test was negative bilaterally. Sensation to pinprick and light touch were decreased with pinwheel of the left lower extremity, there was decreased lumbar extension and right lateral bending, abdominal strength of 4/5 bilaterally, hip flexors and extensors 4/5 bilaterally, the inability to abduct or adduct due to pain, quadriceps and hamstring strength of the knee was 4/5 bilaterally, extensors, flexors, evertors off the ankle and strength of the great toe extensors and flexors were 4/5 bilaterally. Lumbar herniated nucleus pulposus L4-5 and left annular tear of the disc were diagnosed. Dr. did not feel she was at maximum medical improvement, but was anticipated to be 03/19/09.

Dr. re-evaluated the claimant on 12/22/08 for ongoing back pain. She moved slowly and stiffly and grimaced a lot, and exhibited pain behavior. Active straight leg raise while seated showed pain, numbness of both legs, bilateral positive distraction test, normal big toe strength, normal reflexes, no pain with axial compression, the ability to assume a supine position without difficulty, Hoover showed the claimant raised each leg approximately 30 degrees with pain behavior and shaking of both legs. She required assistance in sitting up from a supine position. She was to return to work without restriction. At the 01/29/09 followup the examination showed low back pain with active straight leg raise, numbness of the right leg with slump testing, positive distraction test on the right, the ability to lie supine very rapidly without assistance, negative bilateral straight leg raise, but complained of pain of the right leg from the hip injury, positive straight leg raise on the right, required assistance to sit up from supine and was able to heel/toe walk but refused to squat due to right hip pain. Worsening low back pain radiating to both legs was noted on 02/10/09 since falling at home on the weekend. The examination showed low back pain with active straight leg raise, positive distraction test bilaterally, aggravation of symptoms with slump testing, she rose each leg off the table without effort, straight leg raise was indeterminate, but caused low back pain, spams in the lumbar paraspinal muscles. Patrick and Lasegue were not accomplished due to right hip pain. She was released to work with restrictions. She moved slowly and stiffly and exhibited pain behavior, had an antalgic gait and was able to heel/toe walk with difficulty on 03/10/09.

PA for Dr. saw the claimant on 06/22/09 for continued low back pain radiating into the left buttock, left posterior thigh, left calf and foot. Her gait was abnormal in stance and swing phase, there was tenderness to palpation of the bilateral paraspinal, 3/5 left extensor digitorum longus and brevis, limited active motion and +/- right straight leg raise. She was referred to Dr., chronic pain specialist. Electrodiagnostic studies on 07/08/09 showed possible left sided L5 lumbar radiculopathy. Polyphasic motor unit potentials were identified exclusively, indicative of an inactive or chronic process. There was no evidence of lumbosacral plexopathy, focal compression neuropathy of the lower extremity, peripheral neuropathy or myopathy. Dr. saw the claimant on 08/05/09 for low back and leg pain with numbness and tingling in the legs. Therapy and an epidural steroid injection had provided partial relief. There was decreased lumbar motion, mild to moderate paraspinal tenderness around L4-S1, pain into both buttocks, both thighs and calves, positive straight leg raise

bilaterally. Bilateral transforaminal epidural steroid injection at L4-5, Norco and Ambien were recommended.

The claimant continued treating with Dr., , PA for low back, right hip and bilateral leg pain through 12/09. Conservative care included medications, selective nerve root block, light duty, and epidural steroid injections. PAC for Dr. saw the claimant on 01/19/10 for severe low back pain down both legs to the feet with numbness and weakness and numbness of the buttocks at times. Her feel felt cold and tingly. She reported only 20 percent relief from the 12/23/09 epidural steroid injection. She ambulated with a cane. The examination showed moderately decreased flexion and pain with motion, paraspinal tenderness L4-5 and L5-S1, bilateral sciatic notch tenderness, motor sensory deficit in L4-5 and L5-S1 bilaterally, pain down both legs, atrophy in the gastrocnemius muscles greater on the right, weakness of the lower extremities, decreased sensation in the feet and positive straight leg raise bilaterally at 70 degrees. She was to return to Dr. to discuss surgery. A behavioral medical evaluation on 01/19/10 recommended routine monitoring and medical management conferences with TP. Proposed interventions include ongoing consultative services, continued rehab cognitive skills training, and integrated physical and behavioral medial services. Dr. performed a medical evaluation on 01/20/10 and determined the claimant had not reached maximum medical improvement and could work in a sedentary level of demand from xx/xx/xx to present.

saw the claimant on 01/28/10 noting pain with aquatic therapy sessions. There was L4-S1 bilateral paraspinal tenderness, SI joint left, antalgic gait, positive left straight leg raise, midline tenderness to palpation, limited active motion and pain with extension/flexion. Strength, reflexes and sensation were normal. On 02/16/10 recommended a TENS unit trial which she found helpful for alleviating flares. The 03/16/10 examination was unchanged. The claimant was seen by an unknown physician on 03/17/10 noting no relief from the second injection, unchanged back and bilateral leg pain to the feet. The examination showed moderate L5 tenderness and moderate diffuse tenderness lumbar spinous process., moderate bilateral lumbar paravertebral muscle spasm, decreased lumbar flexion, negative straight leg raise, no limp and normal strength, reflexes and sensation. Displacement of lumbar intervertebral disc without myelopathy and discogenic syndrome were diagnosed. Discography at L3-4, L4-5 and L5-S1 was recommended, but denied on a 04/01/10 review. re-evaluated the claimant on 04/05/10 for shooting pain down the right leg to the calf. On examination she used a cane, was tilting right forward, had midline tenderness to palpation, bilateral paraspinal tenderness of L5-S1 and SI joint on the right, limited motion with extension and pain with flexion and extension, +/- right straight leg raise. re-evaluated the claimant on 04/13/10 at which time strength was 5.0 bilaterally. The examination was otherwise unchanged. Nucynta was refilled and she was to continue Neurontin and Ambien CR and was referred to Lesley Caldwell, LPC For psychiatric evaluation for the lumbar discogram. The discogram was denied again on 04/27/10. saw the claimant again on 05/06/10 noting worse back pain with sitting and bending forward. The examination showed an abnormal gait in swing phase, particularly at acceleration, midswing and deceleration. There was midline tenderness to palpation of L5-S1, bilateral paraspinal tenderness and of the SI joint, limited motion in extension and flexion with pain and negative bilateral straight leg raise.

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

The requested lumbar discogram at L3/4, L4/5, L5/S1 is not medically necessary based on review of this medical record. This is a woman who has had a multitude of back, hip and leg complaints following two events which occurred in xx/xx. She has been seen by numerous physicians, some of which have documented positive physical findings and some of which have documented nonspecific complaints. Recently her physicians have requested a lumbar discogram to determine whether she has low back pathology causing her symptoms. She has had injections and lumbar MRI in the past, documenting L4/5 disc abnormality.

She has had an EMG documenting some questionable left L5 radiculopathy and it does not appear that any of her treatments have changed her complaints. She takes a number of different medications for her complaints. ODG Guidelines indicate there is not good indication for a lumbar discogram. There is orthopedic literature indicating there are significant false/positive false/negative statistical results with discograms and it is very difficult to use a discogram to try to determine whether or not someone has disc pathology causing back pain. The vast majority of discograms is to rule out an issue rather than rule in an issue which appears to what is being requested in this case. Therefore in light of the fact the claimant has changing physical findings and there is nothing documented in the medical record that would specifically link her complaints to a single level, then the discogram is not medically necessary and falls outside of ODG Guidelines. The reviewer finds that medical necessity does not exist for Outpatient lumbar discogram at L3-4, L4-5, L5-S1 levels.

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) (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-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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)