

Notice of Independent Review Decision

DATE OF REVIEW:

02/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar discogram with discography between 01/04/2010-03/05/2010.

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

Doctor of Osteopathy, Board Certified Anesthesiologist, Specializing in Pain Management

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.

Lumbar discogram with discography between 01/04/2010-03/05/2010 is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 02/17/10 letter from, P.C.
- 02/16/10 MCMC Referral
- 02/08/10 Notice Of Assignment Of Independent Review Organization, DWC
- 02/08/10 Notice To Utilization Review Agent of Assignment, DWC
- 02/08/10 Notice To MCMC, LLC Of Case Assignment, DWC
- 02/03/10 Confirmation Of Receipt Of A Request For A Review, DWC
- 02/02/10 Request For A Review By An Independent Review Organization
- 01/11/10 report from ESIS Utilization Review Unit
- 01/11/10 report from, DO,
- 01/04/10 report from ESIS Utilization Review Unit
- 01/04/10, 12/01/09 Workers' Compensation Request Information, M.D., Spine Pain Solutions
- 12/04/09 report from ESIS Utilization Review Unit
- 12/04/09 report from M.D.,
- 12/18/08 to 12/01/09 Established Patient Encounters, , M.D., Spine Pain Solutions
- 10/15/09 Presurgical Mental Health Consultation, MA, Mind & Body Wellness
- 08/31/09 MRI lumbar spine, Imaging Services
- 08/05/09 Peer Review, M.D.
- 08/05/09 letter from, M.D., RGVO

- 07/02/09 cash register receipt, HEB, with prescription label for Hydrocodone
- 06/16/09 Electrodiagnostic Study – Initial Office Visit, D.O.
- 02/24/09, 01/15/09, 11/20/08 Health Insurance Claim Form, M.D.
- 02/11/09 Report for Medical Evaluation – Impairment Rating, M.D., Diagnostic & Occupational Center
- 02/11/09 (Date of Exam) Report of Medical Evaluation, DWC
- 02/06/09 to 09/09/09 office notes, “GRP”, Orthopedics
- 01/15/09, 11/20/08 Procedure Note, M.D., Spine Pain Solutions
- 01/11/08 to 09/09/09 Work Status Reports, DWC
- 12/08/08 letter from, M.D.
- 11/25/08 Referral, M.D., Spine Pain Solutions
- 11/10/08 New Patient Encounter from M.D.
- 10/21/08 report from DWC (not written in English)
- 08/26/08 MRI lumbar spine, Imaging Services
- 07/17/08 Employee’s Notice Of Injury, Workers’ Compensation Commission
- 07/17/08 to 10/02/08 chart notes, Medical Clinic
- Undated form letter from Medical Clinic Office Staff
- Undated PE File notes, Spine Pain Solutions
- Undated note stating claimant did attend physical therapy for one or two days
- Undated Procedure Summary – Low Back
- Undated Work Status Report

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a male with date of injury xx/xxxx. The MRI of 08/2008 showed herniation of nucleus pulposus (HNP) at L1-S1. The injured individual had transforaminal epidural (TFE) injections twice with great relief and for most of 2009 was noted to be doing better. It was not until another TFE was denied in 08/2009 that the attending physician (AP) suggested getting a new MRI and discogram. The injured individual had an electromyogram (EMG) that indicated a right S1 pathology and the surgeon noted L5/S1 findings on exam as his diagnosis. The new MRI showed the same thing as the old MRI. The injured individual had an Independent Medical Exam (IME) in 08/2009 that indicated no surgery was needed. The injured individual had a psychological evaluation that cleared him for surgery.

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

The MRI showed herniated disc pathology at L1-S1 in 08/2008 and again in 08/2009; there has been no change. The injured individual has L5/ S1 symptoms and an EMG showed right S1 radiculopathy. He had great benefit from epidural steroid injection (ESIs) and only when these were denied was a discogram suggested. He had an IME in 08/2009 that stated he needed no surgery. A discogram itself is considered investigation/experimental (I/E) as far as a diagnostic test. The AP never indicates what levels he wants to test and the MRI showed pathology everywhere which highly questions his surgical candidacy. For all these reasons, it is denied.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines:

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) (Pneumatics, 2006) (Airaksinen, 2006) (Manchikanti, 2009) 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) This recent RCT concluded that, compared with discography, injection of a small amount of bupivacaine into the painful disc was a better tool for the diagnosis of discogenic LBP. (Ohtori, 2009) Discography may cause disc degeneration. Even modern discography techniques using small gauge needle and limited pressurization resulted in accelerated disc degeneration (35% in the discography group compared to 14% in the control group), disc herniation, loss of disc height and signal and the development of reactive endplate changes compared to match-controls. These findings are of concern for several

reasons. Discography as a diagnostic test is controversial and in view of these findings the utility of this test should be reviewed. Furthermore, discography in current practice will often include injecting discs with a low probability of being symptomatic in an effort to validate other disc injections, a so-called control disc. Although this strategy has never been confirmed to increase test validity or utility, injecting normal discs even with small gauge needles appears to increase the rate of degeneration in these discs over time. The phenomenon of accelerated adjacent segment degeneration adjacent to fusion levels may be, in part, explained by previous disc puncture if discography was used in segments adjacent to the fusion. Similarly, intradiscal therapeutic strategies (injecting steroids, sclerosing agents, growth factors, etc.) have been proposed as a method to treat, arrest or prevent symptomatic disc disease. This study suggests that the injection procedure itself is not completely innocuous and a recalculation of these demonstrated risks versus hypothetical benefits should be considered. (Carragee, 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 Official Disability Guidelines.

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