

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW: SEPTEMBER 7, 2010**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar discogram with post CT 62290, 72295, 72132

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

Certified, American Board of Orthopaedic Surgery

**REVIEW OUTCOME**

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**TDI**

- Utilization reviews (07/14/10, 08/19/10)

**Dr.**

- Office visits (01/14/08 - 07/28/10)
- Diagnostic tests (03/04/08 - 06/20/10)
- Procedures (10/21/08 - 07/16/09)
  
- Office visits (06/07/10 - 06/28/10)
- Diagnostic tests (06/01/09 - 06/18/10)

**Workers' Comp Services**

- Office visits (06/07/10 - 07/28/10)
- Diagnostic tests (06/18/10)

**ODG has been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who fell off a six foot ladder on xx/xx/xx. He landed supine causing immediate lumbar and left leg radicular pain along with a calcaneal fracture.

Initially, the patient was treated with physical therapy (PT), medications, epidural steroid injection (ESI) x2 followed by a microdiscectomy at the L5-S1 level on September 4, 2007; without any relief of his leg pain and further progression of the lumbar pain. This history is according to Dr.; no interval records are available.

**2008:** M.D., noted constant and progressive lumbar pain associated with bilateral leg discomfort, tingling, weakness and fatigue. The symptoms began in the gluteal region through the posterior thigh, popliteal fossa and posterior calf. X-rays of the pelvis were unremarkable while x-rays of the lumbar spine revealed a left L5-L1 hemilaminectomy and possible L5 pars fracture. Dr. diagnosed lumbar radiculopathy and spondylosis and opted for a conservative approach and recommended to lose weight.

Magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) Hypertrophic degenerative changes in the facet joints bilaterally throughout the lumbar spine. (2) Changes of laminectomy at L5 with fibrosis at paraspinal soft tissue and the lumbar spinal canal involving left first/second nerve root. (3) Hypertrophic degenerative changes in the facet joint bilaterally throughout lumbar spine worse on the right at L4 and L5. (4) Degenerative disc disease (DDD) at L5-S1. (5) Mild posterior central and left posterior paracentral herniated disc at L2-L3 and L5-S1. (6) Minimal degenerative joint (DJD) changes of the lumbar spine.

Dr. obtained lateral flexion/extension films which revealed slight decreased disc height of L5-S1. He diagnosed lumbar reherniation and recommended a lumbar discogram to identify if the patient had any discogenic pain as a major contributing factor to his low back pain. The lumbar discogram was denied.

Computerized tomography (CT) of the lumbar spine revealed: (1) Mildly diminished intervertebral disc space height at L1-L2. Small diffuse anterior osteophytes. Defect of the pars interarticularis on the left at L5. Sclerosis of the opposite bony margins of the defects with hypertrophic change along the posterolateral margin of the endplate on the left at L5-S1. (2) L2-L3 and L3-L4: Mild ligamentum flavum hypertrophy and disc bulging with mild canal stenosis. (3) L4-L5: Facet arthrosis with mild facet gapping, ligamentum flavum hypertrophy, disc bulging and moderate canal and mild foraminal stenosis. (4) L5-S1: Left pars defect with hypertrophic changes and osteophytic impingement to a moderate degree in the neural foramen on the left.

Dr. administered left L4-L5 transforaminal ESI, left L5 selective nerve root injection with complete relief of the left leg radicular symptoms as well as the left-sided lumbar pain and also a right sacroiliac (SI) joint injection for sacroiliitis.

**2009:** In May, Dr. noted severe low back pain on returning to work. Lumbar flexion/extension films showed an L4-L5 spondylolisthesis going from 2 to 7 mm. The patient was prescribed Celebrex, Nexium, tramadol and Soma, but he wanted to have a spinal surgery to improve his pain and be functional again.

MRI of the lumbar spine revealed: (1) Left side hemilaminotomy of L5-S1. (2) L2-L3: Central disc protrusion with minimal to moderate canal stenosis. (3) L5-S1: Left hemilaminotomy with broad base disc and facet arthropathy and moderate to severe right neural foraminal stenosis on the left.

Dr. treated the patient with bilateral L4-L5 and L5-S1 facet injection, with 80% relief of lumbar pain as well as complete relief of the lower extremity radicular symptoms including the numbness to his toes.

**2010:** In June, Dr. noted the lumbar pain escalated without any particular event. The patient reported having bilateral radicular symptoms in a shooting pain pattern that radiated posteriorly and symmetrically. Dynamic imaging of the lumbar spine demonstrated decreased disc height of the L5-S1 with the vacuum phenomena over this area, facet arthropathy at L5-S1 and a grade I L4-L5 spondylolisthesis that changed from 1 to 6 mm.

A repeat MRI of the lumbar spine revealed: (1) L2-L3: Disc bulge with a small concentric annular tear seen in the setting of mild facet arthrosis. (2) L4-L5: Facet arthrosis and ligamentum flavum hypertrophy. (3) L5-S1: Deformity of lamina on the left with osteophytic ridging, enhancing tissue in the lateral recess on the left consistent with epidural fibrosis, asymmetric bulging of disc into the neural foramen on the left producing moderate left foraminal stenosis.

On June 28, 2010, Dr. noted the patient was no longer able to work secondary to his pain, which he described as an 8 on a scale of 10. He was able to bend forward to the ankle level with discomfort. Examination revealed painful extension and rotation of the back but a negative straight leg raising (SLR) test. The left Achilles reflex was diminished as compared to the right. Dr. continued Soma, Nexium, Ultram ER and Celebrex and recommended obtaining a lateral flexion and extension lumbar x-rays to evaluate instability of the spine. The patient wanted a spinal surgery to improve his pain and quality of life. A lumbar discogram was ordered to evaluate to discogenic pain.

On July 14, 2010, the request for lumbar discogram with CT was denied with the following rationale: *"The appropriateness and the medical necessity of lumbar discogram post CT are not established. This procedure is requested to evaluate for the discogenic pain of the patient. However, there is no mention that the patient is a candidate for a specific back surgery. To add, this request is of limited diagnostic value since the patient has low back pain. A formal psychosocial assessment was not provided. Furthermore, there is no objective evidence that the patient has failed in the conservative management which includes the PT, medications and exercises. Hence, this request is not substantiated at this time."*

On July 28, 2010, Dr. noted the patient was no longer working because he was unable to control his environment that always exacerbated his symptoms. Although the pain was better it could escalate to levels of 8. Examination revealed the patient could stand for a seated position without any difficulty. The lumbar spine had a guarded motion that exacerbated usually on extension, right

rotation and flexion. The lower extremities were neuromuscularly intact with a positive bilateral SLR test, the right greater than the left at this point. The deep tendon reflexes were symmetrical and intact on the patellar region; however, they were equally diminished on both Achilles. Dynamic imaging of the lumbar spine on flexion and extension demonstrated a grade I L4-L5 spondylolisthesis that changed for a 2 to 8. There was decreased disc height of the L5-S1 with a vacuum phenomenon. There was facet gapping at the L4-L5 on pars articularis fracture at the L5. Dr. diagnosed lumbago, lumbar radiculopathy, L5 pars articularis fracture and lumbar disc derangement. He opined the patient had consistent lumbar pathology to identify his both lumbar and radicular symptoms. However, because the MRI had significant disc pathology, he would like to follow through with an appeal of the lumbar discogram. The patient had multiple disc desiccations and an L2-L3 high intensity zone consistent with an annular tear. Therefore, the lumbar discogram was indicated to identify any type of disc of pathology to be diagnostic.

On August 19, 2010, an appeal for lumbar discogram with post CT was denied based on the following rationale: *“The appropriateness and the medical necessity of an appeal for a lumbar discogram are not established. The rationale for this request is to identify any type of disc of pathology to be diagnostic. However, the evidence based guideline above does not recommend its use. According to the Evidence Base Guidelines above, it stated that this procedure is of limited diagnostic value in patients with chronic back pain. Furthermore, there is limited objective documentation provided that the patient has indeed failed conservative management as manifested by physical therapy, medications and exercises. Also, it was not stated whether this patient is a surgical candidate and that this requested procedure be used as a screening procedure for surgery. The comprehensive psychosocial screening was also not provided in the medical record. Hence, this request is not substantiated at this time.”*

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

BASED ON THE DOCUMENTATION PROVIDED, AND BASED ON THE RATIONALE OF THE REVIEWERS, THE DENIAL OF THE REQUESTED PROCEDURE APPEARS TO HAVE BEEN APPROPRIATE AND IN ACCORD WITH ODG CRITERIA.

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**