SENT VIA EMAIL OR FAX ON
Oct/14/2011

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Oct/14/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Low Pressure Lumbar Discogram ((performed in-office) with Post Discogram CT (at Unicare), at levels L1-L2, and L2-L3, CPT Codes 62290, 72295, 77003, and 72132

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

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
OD Guidelines
Request for IRO 09/27/11
Utilization review determination 09/12/11
Utilization review determination 09/22/11
Request for IRO 09/23/11
Designated doctor evaluation 08/01/11
Battery for health improvement two 03/23/11
Electrodiagnostic studies 02/23/11
MRI lumbar spine 04/08/10
CT lumbar spine 04/08/10
MRI cervical spine 04/09/10
CT cervical spine 04/09/10
Operative report 08/10/05
Operative report 01/03/05
Operative report 07/26/04
Operative report 04/07/03
Clinical records Dr. 01/31/11 through 09/06/11
IRO Decision dated 05/16/11
Peer Review dated 11/12/10
Physical Therapy progress notes
Clinical Synopsis Pages 4 -23
Clinical Note Dr. dated 08/30/02

PATIENT CLINICAL HISTORY SUMMARY

The claimant's a female who's reported to have a date of injury of xx/xx/xx. On this date she is reported to have been involved within an altercation with a student while restraining the student she twisted her back and strained her neck. She subsequently developed back pain and right buttocks pain. She was initially seen by Dr. The records indicate that the claimant has an extensive pre-injury surgical history. On 04/07/03 the claimant was taken to surgery by Dr. for a diagnosis of lumbar discogenic low back pain at L3-4 with spondylosis and stenosis with radiculopathy. She underwent pedicular segmental instrumentation at L3-4 with TLIF posterior lumbar interbody fusion at L3-4 transverse laminar fusion at L3-4 with decompressive laminectomy with facetectomy at L3-4. She was subsequently returned to surgery on 07/26/04 with a diagnosis of a non-mobile pseudoarthrosis. She underwent removal of segmental instrumentation refusion insertion of a bone growth stimulator utilizing left posterior iliac crest bone graft. On 01/03/05 the claimant was returned to surgery with a diagnosis of lumbar stenosis at L4-5 with possible pseudoarthrosis. There was no evidence of gross motion at the L4-5 level but poor lateral intertransverse fusion with a non-functioning osteostimulator and lumbar stenosis at L4-5 fairly advanced with left greater than right. She underwent a posterior decompressive laminectomy at L4-5 with removal of a bones osteostimulator inspection of fusion dural repair with laminectomy at L4-5 for small barrow lead.

The claimant was returned to surgery on 08/10/05 for possible pseudoarthrosis at L3-4 spondylisthesis at L4-5 with spondylitic disc degeneration L5-S1 with right lower extremity radiculopathy. She subsequently underwent anterior discectomy at L4-5 and L5-S1. Femoral allograft ring reconstruction at L4-5 and L5-S1 with anterior lumbar plating at L3-4 and L5-S1. The records include MRI of the lumbar spine dated 04/08/10 which notes no evidence of focal disc bulge or herniation at L1-2. At L2-3 there's a mild retrolisthesis associated disc bulging with mild bilateral foraminal narrowing moderate canal stenosis seen with facet hypertrophy. At L3-4 L4-5 and L5-S1 the claimant is status post anterior fusion with decompression of the canal with no foraminal narrowing noted. CT of the lumbar spine was performed on this same date. This study notes a grade 1 retrolisthesis with associated disc bulging at L2-3 with mild narrowing of the canal and foramina. Fusion appears solid at L3-4 L4-5 and L5-S1. MRI of the cervical spine was performed on 04/08/10 which notes disc desiccation at C3-4 with a slight anterolisthesis of C3 on 4 moderate to marked left foraminal stenosis secondary to left facet arthropathy mild slight foraminal stenosis with no central canal stenosis. At C4-5 there's mild disc degeneration with no central canal stenosis moderate bilateral foraminal stenosis moderate left facet arthropathy. At C5-6 there's mild disc degeneration with no central canal stenosis moderate right foraminal and mild left foraminal stenosis marked right facet arthropathy. There are mild degenerative changes at C6-7 and C7-T1. CT of the cervical spine was performed on this same date. It's noted that there's marked degeneration between the anterior area of C1 and the odontoid process at C2-3 there's moderate disc degeneration. At C3-4 there's mild disc degeneration there's a grade 1 spondylisthesis of C3 on C4. There's marked bony left foraminal stenosis secondary to left facet arthropathy. At C4-5 there's moderate disc degeneration with no central canal stenosis marked bony left foraminal stenosis secondary to facet arthropathy with mild right foraminal stenosis at C5-6 there's moderate disc degeneration with no central canal stenosis moderate to marked bony right foraminal stenosis secondary to right facet arthropathy with moderate mild to moderate degenerative changes at C6-7 and C7-T1. The claimant was referred for electrodiagnostic studies on 02/23/11 which report electrodiagnostic findings of signs of reinnervation on the right consistent with radiculopathy in higher lumbar cord levels.

On 03/23/11 the claimant was referred for battery for health improvement two.

On 03/31/11 the claimant was seen by Dr.. She presents for evaluation of cervical and lumbar injuries. She has previously been under the care of Dr. She's reported to have developed problems with numbness around her rectum and difficulty controlling her bladder. The claimant was diagnosed with instability at L2-3. Dr. a spinal surgeon said he would not do any additional surgeries and referred the claimant or the claimant requested to change treating doctors. She's further noted to have a history of bilateral knee replacements one in

2001 and one in 2002. Her lumbar surgery is documented above. The claimant reports that her back symptoms improved after her 2005 surgery and she returned to work in 2008. She had no doctor follow ups between 2008 and the time of injury. On physical examination she is noted to have 2/5 motor weakness in the EHL on the right 3/5 on the left. Ankle dorsiflexors are 4/5 bilaterally. Ankle plantar flexors are 4/5. The patient has diminished sensation along her bilateral L5 distribution her patellar reflexes are 2+ and symmetric. Achilles are 1+ and symmetric. She has no beats of clonus. Her hip abductor and flexor strength is 4/5. Radiographs of the lumbar spine demonstrate fusion from L3-S1 with an anterior plate at L4-5 and L5-S1. Dr. suggests that her fusion can be extended to include L2-3 but prior to that he would like to see her actual studies.

Claimant was seen in follow up on 03/03/11. On examination of the on physical examination her physical examination at this visit is unchanged. Imaging studies were discussed. She's opined to have a retrolisthesis at L2-3 with mechanical discogenic back pain. She's status post fusion and a dural repair. She's to be referred for psychological screening to rule out any barriers to recovery. She was provided oral medications. The claimant was seen in follow up on 04/04/11. Radiographs were performed including flexion and extension views. Her physical examination is unchanged. It's reported that flexion extension radiographs reveal some instability at the L2-3 level. At this visit Dr. subsequently recommends that the claimant undergo lumbar discography to confirm that L2-3 is painful generator. As the primary pain generator he recommends extension of fusion to include the L2-3 level.

On 07/18/11 it was reported that discogram was ordered which was subsequently denied on utilization review. This went to IRO who disagreed with the request for discogram and the request for CCH was made. CCH was withdrawn due to an ongoing extent of injury dispute. She reports that she has been having incontinence of stool and she woke up and found that she had been incontinent. She's pending designated doctor evaluation in Galveston on 08/01/11. Her physical examination remains unchanged.

The records include a designated doctor evaluation dated 08/01/11. Portions of the report are redacted. She presents with complaints of pain in the lower back left bilateral lower extremities with numbness and tingling weakness of both legs and buttocks. On physical examination she's six feet tall weighs 215 pounds. Lower extremity reflexes are 2 and symmetric. There is tenderness over the L2-3 vertebra with no paravertebral muscle spasms. Straight leg raise was negative bilaterally. Sitting root test was negative. Sensory is reported to be intact. She's noted to have 5/5 strength in the bilateral lower extremities. It would appear from this report that the designated doctor opines that the claimant sustained an L2-3 injury. She presented for physical examination on 09/06/11 or was seen in follow up on 09/06/11. She's noted to have tenderness to the mid and lower lumbar region with decreased range of motion with flexion and extension she has 4/5 motor strength in her EHL bilaterally. Flexor hallucis longus bilaterally foot evertors bilaterally quadriceps strength is reported to be 5/5 on the right and 4/5 on the left. She's reported to have diminished sensation in her buttock and thigh region along her bilateral L5 distribution. She subsequently is recommended to undergo lumbar discography. The initial review was performed on 09/12/11 by Dr. who non-certifies the request noted that discography is not recommended per Official Disability Guidelines and is irrelevant to this claimant. He notes that discograms in listhotic discs have been poorly studied and the predictive value is unknown. He further notes that the decision to operate or not to operate on this patient would be made based on the symptoms and the listhesis present on imaging. And that a negative discogram will not rule out the need for surgery. Subsequent appeal request was reviewed by Dr. noting that medical necessity was not established

Additional medical records were submitted for review 10/12/11 and considered in the decision.

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

The request for lumbar discography low pressure lumbar discogram with post discogram CT at L1-2 and L2-3 is not medically necessary and the previous utilization review

determinations are upheld. The submitted clinical records indicate that the claimant has a history of extensive spinous surgery and is fused from L3 through L5. She is opined to have sustained an injury at the L2-3 level secondary to an altercation. There is some evidence of instability at this level and there is a grade 1 listhesis noted. It is clear from the submitted medical records that the claimant has an adjacent segment injury and surgical intervention will be based on instability at this level. Low pressure discography will not alter the course of the claimant's treatment as there is clear evidence of adjacent segment disease and injury. It would further be noted that the claimant has not undergone an appropriate pre-procedure psychiatric evaluation as required by the Official Disability Guidelines to address any potentially confounding issues which would skew the results of the study. There is a clear inconsistency in the claimant's clinical presentation noting that on the designated doctor evaluation the claimant has no motor strength or sensory or reflex changes noted. This portion of the examination is entirely normal yet when seen prior to this and subsequently after this the claimant is reported to have 4/5 motor strength in the EHL flexor hallucis longus and foot evertors bilaterally as well as sensory loss and reflex changes. There's a clear lack of correlation between the independent physical examination and that as reported by the requester. Based upon the totality of the clinical information the claimant does not meet criteria for lumbar discography and further the performance of lumbar discography will not alter the claimant's surgical course.

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

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

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES