

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: January 5, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Discogram with CT at Levels L3-4, L4-5 and L5-S1 between 12/1/2011 and 1/30/2012.

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

This physician is Board Certified in Neurological Surgery with over 40 years of experience.

REVIEW OUTCOME:

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

- Upheld _____ (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

02-25-11: MRI of the Lumbar Spine interpreted by MD
03-24-11: Worker's Compensation Initial Evaluation Report by DC
06-23-11: Medical Report by MD
07-20-11: Report of Medical Evaluation by DO, Designated Doctor
08-15-11: Follow-up Evaluation by MD
08-19-11: Operative Report for a Lumbar Myelogram performed by, MD
08-19-11: Lumbar Myelogram interpreted by MD
08-19-11: CT Lumbar Spine interpreted by MD
09-15-11: Follow-up Evaluation by MD
10-18-11: Individual Therapy note by MD and RN
10-19-11: A Letter of Medical Necessity by MD and RN
10-25-11: Follow-up Evaluation by MD
11-17-11: Follow-up Evaluation by MD
11-28-11: UR performed by MD
12-07-11: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was employed by when he was struck in the back by drilling tongs and fell 7 feet to the deck. He was initially seen at and then referred to DC by Dr..

02-25-11: MRI of the Lumbar Spine interpreted by MD. Impression: 1. Broad based posterior disk bulging present at the L5-S1 encroaches on the left neural foramen effacing the paraneural fat and fascia and possibly causing some mild impingement on the exiting left nerve root. 2. Otherwise normal MRI of the lumbar spine.

03-24-11: Worker's Compensation Initial Evaluation Report by DC. Dr. noted he was experiencing constant lower back pain, muscle spasm and pain down both legs. On physical examination he had positive Ely's Heel to Buttock, Farfan Torsion Test and SLR on the right. He also had restricted ROM and trigger points were active with radiation into the low back at the gluteus maximum and piriformis. Dr. recommended treatment that would consist of therapy three times per week for four weeks, including therapeutic exercise.

06-23-11: Medical Report by MD. Dr. noted the claimant had complaints of severe low back pain and bilateral radiating hip and leg pain with numbness and dysesthesias in the legs. He had been treated with chiropractic care and physical therapy. An epidural steroid injection did not help. He had been on Hydrocodone and Flexeril. On physical examination he walked with a flexed posture to the low back. He had paralumbar muscular tightness and limited mobility of the low back. There was some tenderness over both sciatic outlets. Straight leg raising was positive bilaterally at 45 degrees. There was no pain with hip rotation. He was able to stand on his toes and on his heels, but with some difficulty. He had a bilateral antalgic wide-based gait. Deep tendon reflexes were 1+ in the knees and trace in the ankles. He had no pathologic reflexes.

He had no muscular atrophy or fasciculations. There was no definite dermatome sensory deficit. Dr. diagnosed lumbosacral strain/contusion problem with superimposed L5-S1 disk herniation with a chronic mechanical low back disorder and radiculopathies. A lumbar myelogram with CT was recommended along with continuing chiropractic care. He was prescribed Ultracet, Flexeril, and Motrin 800 mg.

07-20-11: Report of Medical Evaluation by DO, Designated Doctor. Dr. opined that the claimant had not obtained maximal medical improvement. Dr. diagnosis included radiculitis at L4-L5 bilateral intermittent, lumbar sprain/strain, contusion of the right elbow and lumbar IVD disorder without myelopathy.

08-15-11: Follow-up Evaluation by MD. Dr. noted the claimant was getting worse in spite of good conservative measures. It was also noted the Ultram did not give him any benefit and was placed on Hydrocodone 7.5 mg. Dr. was continuing to try to get a Lumbar Myelogram with CT approved.

08-19-11: Operative Report for a Lumbar Myelogram performed by, MD.

08-19-11: Lumbar Myelogram interpreted by MD. Impression: Thecal sac deformity as described above. (There is blunting of the left nerve root sleeve at L5 and to a lesser extent the right nerve root sleeve of L5 which may be due to impingement. There is disk space narrowing at L5-S1 with lower lumbar facet disease present.)

08-19-11: CT Lumbar Spine interpreted by, MD. Impression: Multilevel degenerative change from L3 to L5-S1.

09-15-11: Follow-up Evaluation by, MD. It was noted that the claimant was having increasingly severe lumbosacral pain and bilateral radiating hip and leg pain, worse on the left. It was reported he had physical therapy and chiropractic care and has had steroid injection and continued to require medication including Hydrocodone, Flexeril, and Motrin. He walked with a flexed posture at the low back, straight leg raising was positive on the right at 45 degrees and on the left at 30 degrees, and ankle reflexes were depressed. Dr. recommended a L5-S1 decompression, fusion, and instrumentation for treatment of his problem.

10-19-11: A Letter of Medical Necessity by MD and RN. It was reported that the claimant had participated in a Pain Management Program for 10 days and had made good progress in physical function. The progress indicated a need to request a continuation of treatment in effort to prevent a lumbar fusion.

10-25-11: Follow-up Evaluation by MD. It was reported that the claimant had a psychological evaluation. On physical examination, Dr. could not find any differences on his spinal or neurologic examination. Although he did go on to state that the examination showed very severe lumbosacral disc pathology with diminished mobility, tenderness over the sciatic outlets, loss of lumbar lordosis, paralumbar muscular

tightness and positive straight leg raising bilaterally. Dr. continued to recommend surgery.

11-17-11: Follow-up Evaluation by MD. Dr. reported the proposed surgery was again denied, even though the claimant had severe post-traumatic disease at L4-5 and L5-S1 with herniated disk, stenosis, and root compression. Dr. noted the claimant had failed all forms of conservative measures. He also stated the claimant had very severe mechanical pain in the lumbar spine in addition to his radicular hip and leg pain with neurologic deficit. Dr. recommended lumbar discography at L3-4, L4-5, and L5-S1 for further diagnostic studies since he was unable to get the surgery approved.

11-28-11: UR performed by MD. Reason for Denial: The patient stated he has a pain level of 9-10/10 and is utilizing pharmacological methods of pain relief. The patient has completed several physical therapy sessions; the exact amount is not stated in the clinical documentation. The patient has also completed 10 days of the pain management program, with a good response. The patient has received an epidural steroid injection with no change in the patient's pain level. However, the ODG state that only a single level of testing should be performed, also that 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) and that a Discogram is not recommended. Furthermore, the request for a several level discogram is requested and the ODG initially do not recommend a discogram, however if performed it only recommends one level with a control be performed. As such, the request for 1 lumbar discogram with CT at levels L3-4, L4-5, and L5-S1 is non-certified.

12-07-11: UR performed by MD. Reason for Denial: As per latest medical report dated xx/xx/xx, it was noted that the patient has very severe mechanical pain in the lumbar spine in addition to his radicular hip and leg pain with neurologic deficit. It is noted that the patient has attended chiropractic treatments, work conditioning/hardening, and a chronic pain management program; however, there was no documentation that he has failed to improve with these treatments. Furthermore, it was stated that a psychological evaluation of the patient was performed, but no psychological report was provided. Moreover, the current evidence-based guidelines recommend a single-level testing. The records also did not provide documentation that the patient has been educated on the potential risks and benefits of the contemplated procedure. Finally, it is noted that the patient is obese. There is none in the clinical information that addresses this issue which is considered an important factor in the continued back symptoms of the patient. Hence, the previous non certification is upheld.

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

After reviewing the forwarded medical records, it is my opinion that the Lumbar Discogram and CT at Levels L3-4, L4-5 and L5-S1 are not indicated. Per the ODG this

test is very subjective and not recommended. The claimant has already had MRI and Myelogram/CT and there is no documentation that would indicate the need for the Discogram and CT. Furthermore, if it was agreed upon to proceed anyway, the claimant does not meet the ODG criteria. A detailed psychosocial assessment was not available for review, there is no documentation that the claimant was briefed on the potential risks of the procedure, and multiple levels were requested whereas the ODG recommends a single-level testing. Therefore, the previous decisions have been upheld.

ODG:

Discography:

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 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 screening tool to assist surgical decision making, 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- AMERICAN 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**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- 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)**