

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE OF REVIEW: June 4, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Discogram 72295

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

This physician is a Board Certified Neurologist with over 34 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a low back injury on xx/xx/xx when he pushed a pry bar at work.

10/25/11: The claimant was evaluated by MD. He complained of right-sided low back pain and pain in his right leg at times. Pain scale 7/10. On physical exam, he had a mildly antalgic gait with slow and guarded ambulation. He had pain upon palpation of the paraspinal muscles from approximately L3 to S1. He had LROM by pain. Motor strength was 5/5 in quadriceps bilaterally, calves, and hip flexors. Reflexes were +2/4 in patellae bilaterally. SLR negative at 90 degrees

bilaterally. Dr. prescribed a Medrol Dose Pack and Mobic.

10/31/11: The claimant was reevaluated by MD for complaints of pain to the right side lower back, which he stated was increased. He stated that the pain was traveling down his right leg and making his right leg go numb. He stated that he felt like he was going to lose his bladder on himself. Pain scale 7/10. There were no changes on physical exam compared to 10/25/11 with the exception of Waddells' positive for head pressure causing back pain, pelvic twist causing back pain, light skin rolling causing back pain. Dr. planned to request a lumbar MRI and EMG/NCT of the lower extremity.

10/31/11: Lumbar Spine, 3 Views interpreted by MD with Hospitals/Clinics. IMPRESSION: Mild multilevel degenerative disc disease.

11/09/11: EMG Nerve Conduction Study by MD with xxxx. SUMMARY: Prolonged sural latencies with normal amplitudes. Normal motor studies. Normal needle exam of BLE and LS paraspinals. CONCLUSION: No electrophysiological evidence of a lumbosacral radiculopathy or plexopathy at this time. Mild prolonged surals may be age-related changes, less likely an early sensory neuropathy.

11/14/11: MRI Lumbar Spine without Contrast interpreted by, MD with Hospitals/Clinics. IMPRESSION: 1. Probable midline L1-L2 HNP extruded subligamentous behind L2 (incompletely imaged). 2. Left paracentral HNP L5-S1, small to moderate in size.

11/17/11: The claimant was reevaluated by MD who noted that he complained of continuing to have a moderate amount of pain in the lumbar back. Pain scale Lumbar strain/sprain with no evidence of radiculopathy on EMG/NCT. Despite pressure of left eccentric HNP at L5-S1 and another possible small central at L1-L2, these do not correlate with symptoms (symptoms are on the right). PLAN: Refer for spine pain management

12/06/11: The claimant was evaluated by DO who noted that he complained of constant low back pain, bilateral leg aching/cramping, and numbness to toes of left foot and some radiation of pain into right leg as well on a scale of 6. On physical exam, thoracolumbar spine range of motion: flexion, extension, extension, rotation to the left, rotation to the right, lateral flexion to the left, and lateral flexion to the right were all abnormal. Loss of the normal lumbar lordosis was noted. He had no tenderness in the lumbosacral spine on palpation. There was no muscle spasm in the lumbosacral spine. SRL on the left was positive. Decreased response to pain and temperature stimulation decreased in the left foot in L4-L5 distribution and an antalgic gait were observed. The knee jerk was normal. The ankle jerk reflex was abnormal, diminished on the left side. ASSESSMENT: Lumbar radiculopathy. PLAN: Consultation with a specialist, Dr..

12/08/11: The claimant was evaluated by PT, MPT who noted that he complained of constant low back pain, bilateral LE radiating pain, aching, and cramping as

well as numbness to the great toe of the left foot. AROM Lumbar in degrees: Flexion 21, extension 14, RLF 5, LLF 10, RSLR 38, LSLR 28. DTRs were intact and symmetrical. Sensation was intact. Positive Nori and Braggard bilaterally. Positive SLR bilaterally. ASSESSMENT: The patient presents to PT with signs and symptoms consistent with MD diagnosis. He would benefit from skilled PT intervention in order to decrease pain/radicular symptoms, increase ROM, increase strength, decrease muscle tone, improve posture, and increase functional activity tolerance while developing independence with a HEP.

01/11/12: The claimant was evaluated by MD. On physical exam, he had an antalgic gait. ROM: 75% expected lumbar flexion, 50% expected lumbar extension, lateral bending limited left. Motor: Pain inhibited exam except right APF 5/5, left APF 4+. Sensation was intact. DTRs were normal at the hamstrings and knees. IMPRESSION: Left lumbar radiculopathy status post work-related injury 10/11/11. Motor deficit is suggested on exam. EMG reportedly done by Dr. results are unavailable today. 2. Lumbar disc protrusion – MRI 11/14/11 at Hospital demonstrates left paracentral protrusion at L5-S1 deflecting the thecal sac and deflecting S1 nerve and abutting the L5 nerve it appears as well. There is a smaller suggestion of a right paracentral L1-L2 bulge as well, though no axial images obtained. 3. Myofascial pain – recurrent spasm reported. RECOMMENDATION: 1. He continues at light duty work per Dr.. 2. Encouraged him to continue with PT. 3. Reviewed the options, risks, and benefits of transforaminal injection and he wishes to pursue that. To this end, we will schedule for left L5 and S1 lumbar transforaminal epidural steroid injection x 1. 4. Plan to followup two weeks post procedure to review progress with the above, hopefully to allow him to return to higher functional work duties.

01/13/12: The claimant was evaluated by PT, MPT. ASSESSMENT: The patient has made minimal progress in PT. He continues to have significant LBP with accompanying radicular symptoms. I recommend no additional care at this time. PLAN: Discharge PT secondary to lack of progress. I concur with the treating physician that patient would benefit from a surgical consult.

01/20/12: The claimant was reevaluated by DO. There was no change on physical exam compared to 12/06/11. PLAN: 1. Acetaminophen + hydrocodone bitartrate Norco Tablet 5/325 mg. Followup with Dr. as scheduled.

02/14/12: Pain Management Procedure Report by MD with xxxxx. Diagnosis: Lumbar radiculopathy. Procedure: Lumbosacral Transforaminal Epidural Injection left L5 spinal nerve at L5-S1 and left S1 spinal nerve at S1.

02/21/12: The claimant was reevaluated by, DO who noted that he still complained of constant lumbar pain all the time and that he had an ESI last week without any significant benefit. Pain scale 6. Documented physical exam remained unchanged compared to 01/20/12 with the exception of the ankle jerk now being normal. PLAN: Consultation with a neurosurgeon.

04/11/12: The claimant was evaluated by MD who noted that he complained of left leg pain going from the buttocks down the posterior aspect of his leg through

the gastrocnemius into the heel and bottom of his left foot. He also stated that he gets some numbness and tingling in the L5 distribution that is more posterolateral into the top of his foot. He had noticed weakness in the left leg to the point that he no longer climbed stairs unless he just had to. He stated that he had difficulty putting weight on the ball of his foot. He also reported some problems with a mild foot drop at times when he became fatigued and tired. On physical exam, he had a difficult time rising from a chair and walking without keeping his back very straight, which he did rather slowly. He had a slow but steady gait, obviously favoring his left leg somewhat. DTRs: 2+ patellae bilaterally, right Achilles 1 to 2+, left Achilles 0, right plantar flexor 1+, left plantar flexor 0. He had numbness in the S1 greater than L5 distribution on the left. He had significant weakness of the gastrocs. He had difficulty raising his weight up on the ball of his left foot without assistance. He had a slight foot drop when walking on his heel on the left. Otherwise, motor and sensory exams were within normal limits. IMPRESSION: 1. Low back pain. I think his low back pain is probable discogenic in origin. I think he has very significant axial back pain. I think the real question is whether it just involves the L5-S1 disc or both the L4-L5 and L5-S1 discs, or perhaps neither is painful. 2. Left leg pain with weakness, reflex changes and sensory changes all secondary to herniated disc at L5-S1 to the left. PLAN: I think this gentleman is going to need an L5-S1 discectomy for his lumbar radiculopathy and a lumbar fusion for his back pain. I think the biggest questions still present are as follows: 1. Is this discogenic back pain or not? 2. How many levels are involved?

04/12/12: Preauthorization Request by Tyler Neurological Associates, PA. Rationale: Patient is positive for back and left leg pain, numbness & tingling at L5 distribution, leg weakness and foot drop. MRI positive for S1 nerve root compression. Conservative treatment has failed to achieve MMI. Recommending L5-S1 discectomy and fusion. Discogram medically necessary and ODG approved to distinguish asymptomatic discs amount morphologically abnormal discs. Please review all attached medical records.

04/17/12: UR by DO. Criteria used in analysis: The patient's diagnosis already appears to be established with the lumbar disc disease and radicular findings based on the physical exam findings and workup done and discography is unproven and not supported in the guideline criteria in helping to clarify the specific pain generator. Therefore, this request is not medically reasonable or necessary.

04/17/12: Appeal Non-Certification Determination by xxxxxx, PA. Rationale: Patient is positive for back and left leg pain, numbness & tingling at L5 distribution, leg weakness and foot drop. MRI positive for S1 nerve root compression. Conservative treatment has failed to achieve MMI. Recommending L5-S1 discectomy and fusion. Discogram medically necessary and ODG approved to distinguish asymptomatic discs among morphologically abnormal discs. Finally, patient meets ODG criteria as indicated: Back pain of at least 3 months duration, failure of recommended conservative treatment including physical therapy, and MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for internal control injection.

04/24/12: UR by MD. Recommendations: ODG states that 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. There is documentation of a previous adverse determination because the patient's diagnosis already appears to be established with the lumbar disc disease and radicular findings based on the physical exam findings and workup done and discography not supported in the guideline criteria in helping to clarify the specific pain generator. The patient presents with back and left leg pain. Objective findings include numbness and tingling in the L5 distribution, leg weakness, and foot drop. Imaging demonstrates S1 nerve root compression. Conservative care has included PT, lumbar ESI, and medication. Discussion identifies that the patient is considered for L5-S1 discectomy and fusion. Most likely, the patient's pain is L5-S1 discogenic, but if the L4-L5 disc is also concordant with pain, a two-level fusion will be considered. However, the patient does not meet criteria for lumbar fusion as there is no instability or central stenosis and spondylolisthesis. In addition, discussion identifies a rationale that the discogram would be used to rule in a fusion rather than to rule out the level. Therefore, the request is non-certified. Addendum: 04/24/12 4:28 pm phone conversation with Dr. xxxxx. He recognized that there were no clinical or imaging indications for fusion. The MRI did not comment on the L4-L5 segment. No clear indications for discography.

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

Previous decisions are upheld. There is already documentation of radiculopathy on physical examination. Per ODG, discography is not recommended to clarify specific pain generator and would not likely contribute any diagnostic value in this case.

ODG:

Discography	<p>Discography is Not Recommended in ODG.</p> <p>Patient selection criteria for Discography if provider & payor agree to perform anyway:</p> <ul style="list-style-type: none">o Back pain of at least 3 months durationo Failure of recommended conservative treatment including active physical therapyo 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) <p>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.</p> <ul style="list-style-type: none">o Briefed on potential risks and benefits from discography and surgeryo 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)**