

IRO REVIEWER REPORT - WC



Notice of Independent Review Decision[Date notice sent to all parties]: **January 11, 2013**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar discogram L5-S1 with CT 62290 x 1, 72295.26 x 1, 72132

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

American Board of Orthopaedic Surgery

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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

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- 6-1-12 MRI of the lumbar spine
- 7-12-12 Physical Therapy Evaluation.
- Physical Therapy 8-9-12, 9-9-12.
- 8-15-12 office visit.
- 10-5-12 office visit.
- 11-20-12 Ph.D., office visit.
- 11-30-12 MD., Medical Review.
- 12-23-12 MD., Medical Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

6-1-12 MRI of the lumbar spine performed by MD., showed at the L4-5 level, moderate degenerative disc disease is present with mild generalized disc bulging. No focal disc protrusion or spinal canal stenosis is present. At the L5-S1 level, moderate degenerative disc disease is present, without evidence of significant disc bulge, disc protrusion, or spinal canal stenosis. The examination is otherwise normal.

7-12-12 Physical Therapy Evaluation.

Physical Therapy from 8-9-12 through 9-9-12 (2 sessions)

8-15-12 The claimant complains of back pain. The claimant reported she reached out to catch a patient from falling injuring her lower back. Diagnosis: Sprain/strain lumbar region. Plan: The claimant was prescribed Trezix, Flexeril, and Zanaflex.

10-5-12 The claimant presents with back pain that has been going on greater than 6 months and was caused by fall or other injury. The claimant is a nurse and was in the patient's room when that patient lost balance and fell. She went to catch the patient and felt something strain in her lower back. Since then she's had pain in her lower back predominately on the right side indicated with her hand just above the right hemipelvis. She denies significant neurologic symptoms though occasionally she will feel tingling in her right leg in the sciatic nerve distribution. Most of her symptoms are centered in her back. MRI of the lumbar spine dated 6-1-12 from advanced imaging is reviewed by images and report demonstrates advanced

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degenerative disc changes at L5-S1 and very subtle, early degenerative changes at L4-5 area neither level showed severe facet degenerative changes. Assessment: L5-S1 degenerative disc disease with acute low back pain secondary to lifting injury 7 months ago. She has failed physical therapy at this point. She has contraindications to cortisone injection treatment. She has failed medications including anti-inflammatory, muscle relaxers and hydrocodone. Plan: The evaluator does not think he should send her for any cortisone injections given a severe reaction she had to them previously, so the only remaining treatment option given that she has failed physical therapy and medications would be surgical intervention. The evaluator would need to obtain a lumbar discogram which would be preceded by a psychological evaluation to determine if she is a candidate for such surgery. Depending on the results a lumbar disc replacement versus fusion could be considered. She will like to proceed with the pre-discography psych evaluation and subsequently the discogram is complete. New medications for today's visit: Lisinopril, Estradiol, Tegretol, Trazodone, Seroquel, Ambien. Problems added in today's visit: Degenerative lumbar-lumbosacral intervertebral disc, low back pain, hypertension.

11-20-12 Ph.D., the claimant presents for a Psychological Evaluation. Based on this pre-surgical psychological screening she is clear for the discogram, without any concern that psychosocial factors may impact the results of the test. Should she be determined to be a candidate for spine surgery, she would be clear for the surgery, with a good prognosis for pain reduction and functional improvement. The claimant needs a great deal of information and structure in order to achieve maximal gains from the surgery. Be certain to include the client's spouse in treatment planning in order to reinforce improvements and minimize reinforcement of sick role behavior. The client should be given clear expectations about the results of surgery so that a realistic perspective can be developed. The claimant should be referred back for further psychological evaluation if pain does not remit or if progress is slower than expected.

11-30-12 MD., performed a Medical Review. It was his opinion based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, the request for lumbar discogram at L5-S1 with CT is non-certified.

12-23-12 MD., performed a Medical Review. It was his opinion based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, the request for lumbar discogram at L5-S1 with CT is non-certified.

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

This claimant had an injury to the lumbar spine. She sought medical attention and has been treated with medications and physical therapy. She had an epidural steroid injection with an adverse reaction. There has been a recommendation for a lumbar discogram at L5-S1 with CT scan. Her MRI dated 6-1-12 showed at the L4-5

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level, moderate degenerative disc disease is present with mild generalized disc bulging. No focal disc protrusion or spinal canal stenosis is present. At the L5-S1 level, moderate degenerative disc disease is present, without evidence of significant disc bulge, disc protrusion, or spinal canal stenosis. The examination is otherwise normal.

Current literature reflects that discography is not recommended. 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. Therefore, the request for lumbar discogram L5-S1 with CT 62290 x 1, 72295.26 x 1, 72132 is not reasonable or medically necessary.

Per ODG 2012 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 on that disc (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) (Pneumaticos, 2006) (Airaksinen, 2006) (Manchikanti, 2009) 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

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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) More in vitro evidence that discography may cause disc degeneration. (Gruber, 2012) Discography involves the injection of a water-soluble imaging

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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.

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)**