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Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**05/18/2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** L5-S1 lumbar discogram with post CT scan

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** Board Certified Orthopedic Surgery

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

MRI of the lumbar spine dated 10/26/11  
Clinical notes dated 01/19/12 – 04/02/12  
Clinical notes dated 02/09/12 – 06/25/12  
Procedure note dated 02/28/12  
Clinical notes dated 08/13/12 – 03/22/13  
Behavioral medicine evaluation dated 10/05/12  
Prior reviews dated 04/10/13, which was amended on 05/01/13 & 04/25/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who initially sustained an injury on xx/xx/xx after he fell while wearing. The patient developed low back pain and prior imaging studies of the lumbar spine completed in October of 2011 revealed multiple levels of disc desiccation and disc height loss most severe at L5-S1. Moderate foraminal narrowing to the right and mild foraminal narrowing to the left at L5-S1 was noted. There was no evidence of any significant canal or lateral recess stenosis at any level. The patient did undergo injections but continued to report ongoing low back pain. The patient was noted to have been recommended for a lumbar discography in August of 2012. The patient did undergo a behavioral medicine evaluation on 11/05/12. MMPI-2 results raised concerns regarding possible inconsistent reporting or under reporting. There was constant non-responsiveness in the protocol validity. The patient's COMM score was 3 which did not indicate a risk for abuse of narcotic medications. There was a general recommendation for clearance for surgery; however, no specific

procedure was discussed. Clinical evaluation on 12/26/12 indicated the patient continued to have low back pain and was not helped by pain medications. Physical examination at this visit demonstrated pain of the paraspinal musculature that was exacerbated by flexion and extension of the low back. The patient was again recommended for discography at L5-S1. The follow up on 03/22/13 stated the patient continued to have paraspinal tightness at L4-5 and L5-S1 with limited lumbar range of motion. The patient was recommended for an L5-S1 lumbar discogram.

The request for lumbar discography at L5-S1 with post-discogram CT was denied by a utilization review on 04/10/13. This was later amended on 05/01/13. The reviewer opined that there was lack of clinical evidence support for lumbar discography due to high positive rates of disc herniations after a positive discogram.

The request was again denied by a utilization review on 04/25/13 as there was no evidence that fusion procedures were considered.

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

The patient has had ongoing complaints of low back pain despite conservative treatments including injections and pain medications. The patient was continually recommended for an L5-S1 lumbar discogram to determine a pain generator at L5-S1. The clinical documentation submitted for review raises several concerns regarding the requested discography. Primarily, the submitted request is for a single level discogram only. There is no indication that a control level would be utilized during the procedure. Given the lack of a control level, it is unclear how a pain generator can be established with a single level discogram procedure only. The clinical documentation provided for review does not indicate that the patient has failed all other reasonable methods of determining pain generators to include additional diagnostic testing as well as selective nerve root blocks or medial branch blocks. The patient's psychological evaluation was also concerning regarding abnormal validity testing for under reporting or non-responsiveness. This reviewer feels that the psychological evaluation does not fully support a lumbar discogram procedure. Overall the clinical literature does not support a lumbar discography as there is several high quality clinical studies which significantly show that postoperative outcomes from lumbar fusion or other surgical procedures predicated on the response from discogram are generally very poor. In this reviewer's opinion, discography at L5-S1 with post discogram CT is not supported as medically necessary.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

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

Official Disability Guidelines, Online Version, Low Back Chapter

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 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