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Notice of Independent Review Decision

October 31, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Post Discogram CT Lumbar Spine without Contrast - 72131

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

The Reviewer is Board Certified in the area of Anesthesiology with over 6 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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

10/16/2012: Surgical Consultation
01/07/2013: Evaluation
01/07/2013: Evaluation
02/06/2013: Evaluation
02/11/2013: Progress notes
05/02/2013: Evaluation
06/10/2013: Evaluation
07/17/2013: Initial Evaluation
07/22/2013: Lumbar Myelogram
07/22/2013: Postmyelogram CT of the Lumbar Spine
08/13/2013: Evaluation
08/14/2013: Myelogram and Post Myelographic CT Scan
08/20/2013: UR performed

09/09/2013: Evaluation
09/17/2013: Referral
10/11/2013: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a female who was involved in a work related accident on xx/xx/xx where she injured her cervical and lumbar spine. She underwent a cervical fusion in 1995 and a redo of her cervical fusion in 2001. She also underwent Laminectomy L4-5 and L5-S1 in 1998.

10/16/2012: Surgical Consultation. Chief Complaint: Failed cervical spine syndrome with neck pain with primarily low back pain and radiation to both legs. Complaints of neck stiffness with lower back pain, bilateral leg pain with numbness and tingling with failure conservative treatment over the last xx years. Back pain and bilateral leg pain were bothering her. Has worsened recently and presents her for surgical consultation. Radiographs: X-rays of her pelvis reveals hips without degenerative joint disease, sacrollao joints without sclerosis. X-ray of the lumbar spine to include flex/extension views reveals L4-L5 and L5-S1 laminectomy at L4-L5 and laminectomy at L5-S1 with stoffee variant pedicle screws at L4 bilaterally. L5 bilaterally, S1 bilaterally with plating with gross anterior screw penetration of S1 being through the anterior cortex greater than three threads. There appears to be no posterior bone formation. There is no screw fracture. She demonstrates significant adjacent segment disease at L3-L4 with functional spinal unit collapse of 8 num from the standing lateral neutral film, normally 10mm to 2mm at L3-L4 associated with retrollshesis at 10mm and posterior instability criteria of ODG for functional spinal unit collapse, the American Academy of Orthopedic Surgeons Instructional Course. X-ray of the cervical spine to include flexion-extension views reveal anterior cervical decompression discectomy at C4-C5, C6-C7, well healed with no adjacent segment disease at C3-C4. Assessment: Failed cervical spine syndrome. Failed lumbar spine syndrome with misplaced hardware, rule out pseudoarthrosis, L4-L5 and L5-S1 with significant adjacent segment disease. Plan: Will continue her work up with a gadolinium-enhanced MRI scan of the lumbar spine and see her back after this is done.

01/07/2013: Evaluation. Reports of low back and leg pain taking aspirin. Pain has been present for 13 years. Describes the pain as a 10. Pain was located in the lower back and both legs. Pain is dull. She was experiencing sensations of numbness and tingling. Confirms sexual function disturbances. Exacerbating factors include straining, sitting, lifting, sleeping on back, walking (patient was able to walk) and sex. Treatments tried included medications, physical therapy, and injection therapy. Current medications: Seroquel 50mg, Synthroid 25mg, Xanax. Physical Exam: Lumbar Spine: Limited range of motion secondary to pain. Facets, tender to palpation on bilaterally. Straight leg raise was positive for reproduction of lower extremity pain on the bilaterally at 30 degrees. Reflexes bilaterally (L4 1 +, S1 1+). Sensations: Bilateral, 4 over 5. Trigger Points: Paraspinous muscles bilateral. Weakened lumbar paraspinal muscles. Segmental instability seen on xrays, mostly at L3/4. Assessment:

Postlaminectomy Lumbar region. Spondylolisthesis, Postlaminectomy Cervical Region, Encounter for Long-term use of other medications. Plan: Sent authorization for back brace. Prescriptions: Cymbalta 30mg, Cymbalta 60mg, Ms Contin 15mg, Norco 10-325mg.

05/02/2013: Evaluation. Follow up for pain and routine medication and pain review. Patient has been relieved 50, 60% during the last 3 months. The claimant thinks she is allergic to ms contin and would like something else. Pain now is in lower back and thigh down to her leg. She stated her legs felt very heavy. Stated she is also having chest pain and in her neck she heard cracking and popping. She had night spasms in her arm and felt electrical. She had trouble swallowing. She kept choking on food. Still having pain to her liver but now both sides and wants to see how she can have a care taker. No refill on Norco and wanted to change MS Contin. Physical Exam: Limited range of motion secondary to pain. Facets, tender to palpation on bilaterally. Straight leg raise was positive for reproduction of lower extremity pain on bilaterally at 30 degrees. Reflexes bilaterally (L4 1+, S1 1+). Sensations: Decreased to pinprick or light (bilaterally L4, L5, S1) Strength: Bilateral, 4 over 5. Trigger Points: Paraspinal muscles bilateral. Weakened lumbar paraspinal muscles. Segmental instability seen on x-rays, mostly at L3/4. Assessment: Postlaminectomy Lumbar Region, Spondylolisthesis, Postlaminectomy Cervical Region, encounter for Long-Term Use of other medications. Plan: Level of complexity increased due to discussion of initiation or addition of opioid level incurring increased risk of medication side effects, risks and benefits. Prescriptions: Norco 10-325mg, Opana Er 15mg, Xanax 0.5mg. Discontinued MS Contin 15mg.

07/17/2013: Evaluation. Chief Complaints: Constant pain cervical and lumbar spine with radiating symptoms into her upper extremities and lower extremities. Symptoms increased with weight. Patient complains of lumbar spasms and pain across her lumbosacral region. She also complained of upper extremity weakness along with parenthesis in her upper extremities. Her pain lever is at 8. Owesstry Disability index is 78%. Numbness left hand and right forearm also anterior thighs, anterior lateral legs and feet. Assessment: Chronic cervical and lumbar pain with restricted motion weakness of trunk and cervical spine, limited function and weakness. Goals: Increase cervical spine strength, trunk strength, decrease pain 50% and improve function 2 levels on patient's functional survey. Plan: Aquatic therapy with lumbar stabilization and core strengthen, isometrics strengthen for cervical spine, active range of motion exercises, instruct in lumbar and abdominal strengthening. Land exercises

07/22/2013: Lumbar Myelogram. Impression: 1. Degenerative disc disease and findings of degenerative spondylosis at L1-L2, L2-L3, and L3-L4. There is acquired central spinal canal stenosis of at least moderate severity at L3-L4 and mild to moderate central spinal canal stenosis at L2-L3. Mild central spinal canal stenosis at L1-L2 is present. 2. Status post anterior and posterior fusion at L4, L5 and S1.

07/22/2013: Postmyelogram CT of the Lumbar Spine. Impression: 1. Solid L4-S1 anterior and posterior fusion and instrumentation. 2. Abutment of the extraforaminat right L5 nerve root by the right S1 pedicle screw of uncertain clinical significance. 3. Broad based disc herniation at L3-4 with compression of both L3 and L4 nerve roots. 4. Partially calcified broad-based disc herniation at L2-3. 5. Extruded and partially calcified left paracentral disc herniation at L1-2 with moderate compression of the left L1 nerve root.

08/13/2013: Evaluation. Discussed findings of myelogram, post myelographic CT scan, which revealed the mal placed hardware with anterior screw penetration at L5 and both S1 screws along with her adjacent segment disease. Plan: Will continue her workup with provocation discography and post discrographic CT scan at L1-L2, L2-L3 and L3-L4 to document the pain generators and see her back after this is done to see if the hardware can be removed and bone graft the holes or if the discal pathology at the cranial levels needs to be addressed.

08/14/2013: Myelogram and Post Myelographic CT Scan. Lumbar Spine: The review of the myelogram and postmyelographic CT scan reveals instrumented arthrodesis at L4-L5 and L5-S1 with anterior screw penetration at L5 on the right and both S1 screws into the abdominal space along with right L5 nerve root penetration. Interbody arthrodesis appears to be solid. L1-L2, L2-L3, and L3-L4 reveals noncontained disc herniation rated at stage 3 with annular herniation, nuclear extrusion, and disc desiccation consistent with T2-weight image changes and spinal stenosis with retrollathesis of 3mm at L1-L2, retrolisthesis at L2-L3 of 4mm and L3-L4 retrolisthesis of 3 mm. Would recommend provocation discography to delincate clinical symptomatology.

08/20/2013: UR performed. Rationale for Denial: The clinical information submitted for review fails to meet evidence based on guidelines for the requested guidelines. The mechanism of the injury is not provided in the medical records. The patient described the pain as dull and noted that she is experiencing sensation of the numbness and tingling. The physical examination revealed limited flexion and extension of the lumbar spine, facet tenderness upon palpation bilaterally, a positive straight leg raise, and decreased sensation (L4, L5, S1 dermatomes). The myelogram and post myelographic CT scan review noted that instrumented arthrodesis was revealed at L4-L5 and L5-S1 with anterior screw penetration at L5 on the right and both S1 screws into the abdominal space, along with right L5 nerve root penetration. The report also noted L1-L2, L2-L3, and L3-L4 reveals noncontained disc herniation with herniation rated at stage 3 with annular desiccation. The ODG does not recommend the use of discography. In addition to above, the patient would need satisfactory results from detailed psychosocial assessment, which is not included in the provided medical records. It is also noted that due to the high rates of positive discogram after surgery for lumbar disc herniation, it should be a potential reason for non-certification. Given that the request for a discogram is not supported, the request for a post discogram Ct of the lumbar spine without contrast would not be supported. As such, the request for a post discogram CT of the lumbar spine without contrast is non-certified.

10/11/2013: UR performed. Rationale for Denial: The request for post discography CT is not supported as medically necessary. This request is predicated on a prior request for lumbar discography. The claimant is a female who has a history of chronic low back pain secondary to a work related injury on xx/xx/xx. The records indicate that the claimant is status post L4 through S1 fusion and has a diagnosis of failed back surgery syndrome. The records further indicate that the request is for 3 levels. Imaging studies indicate degenerated disc at all three levels and there is no identifiable normal disc to be used as a control. The ODG requires that all patients who undergo discography be referred for a preoperative psychiatric clearance to address any potentially confounding issues which could skew the results of this controversial study. Given the absence of this study medical necessity is not established. Recommend non-certification.

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

The request for post discography CT is not supported as medically necessary. Claimant is a female with a history of chronic low back pain post work related injury on xx/xx/xx. Claimant had a prior request for lumbar discography and is status post L4 through S1 fusion with a diagnosis of failed back surgery syndrome. The records indicate that the request is for 3 levels. Imaging studies indicate degenerated disc at all three levels and there is no identifiable normal disc to be used as a control. ODG does not recommend the use of discography. When it is used, there should be a disc that is used as control and all patients who undergo discography should be referred for a preoperative psychiatric clearance to evaluate the any issues that may skew the results of this controversial procedure. Without a disc level for control and submitted psychiatric clearance, this request for Post Discogram CT Lumbar Spine without Contrast is non-certified.

ODG Guidelines:

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)**