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Notice of Independent Review Decision

April 4, 2014

Amended April 9, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar discogram (62290, 72295 and 72132)

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

Fellowship Trained Orthopedic Spine Surgeon

REVIEW OUTCOME:

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, was pushed while walking up the stairs. His legs swept and he landed on his buttocks causing immediate back pain. In the process, he also hyper flexed both of his knees causing a spasm like pain down to the ankles.

On June 12, 2013, magnetic resonance imaging (MRI) of the lumbar spine was obtained. History indicated an injury in xx/xxxx. There was lower extremity pain and back pain radiating bilaterally to the buttock. The patient also had a history of unspecified lumbar spine surgery ten years ago. MRI revealed small endplate Schmorl's nodes scattered in the lumbar spine, spondylosis with disc bulging and facet arthropathy and susceptibility artifact foci in the posterior soft tissues at the

level of L4-L5 and involving the right L5 lamina suggesting postsurgical changes with laminotomy or hemilaminectomy. At L2-L3, there was anterior endplate spondylosis and mild annular bulging. At L2-L3, there was mild desiccation and loss of height with moderate diffuse annular bulging and endplate osteophytes, thecal sac impingement without central canal stenosis and 3 mm ligamentum flavum hypertrophy. At L3-L4, there was mild desiccation and diminished height, anterior greater than posterior endplate spondylosis, moderate-to-marked diffuse annular disc bulging, left foraminal and lateral extra-foraminal disc protrusions superimposed on annular fissure, 4 mm ligamentum flavum hypertrophy and mild facet hypertrophy and mild spinal canal stenosis with mild left neural foraminal stenosis. At L4-L5, there was disc desiccation, loss of height and diffuse annular bulging with endplate spondylosis, loss of the epidural fat signal on the right, anteriorly around the right L5 descending nerve root, suspicious for epidural fibrosis; broad-based disc herniation measuring up to 6 mm extending from left sub-articular through right foraminal zones; alternatively possibly representing epidural fibrosis. Contrast enhanced imaging could be helpful in attempted differentiation. There was moderate central spinal canal stenosis. There was ligamentum flavum hypertrophy greater on the right measuring up to 6 mm and bilateral facet joint hypertrophy. There was probable L5 laminotomy or hemilaminectomy. At L5-S1, there was a 3 mm central disc protrusion without thecal sac compression or descending nerve root displacement. There was mild facet hypertrophy.

On August 1, 2013, an orthopedic surgeon, evaluated the patient for low back complaints. The patient had sharp and constant lumbar pain. The patient also reported left leg radicular pain radiating along the buttocks, posterior thigh and posterior lower leg. Surgical history was positive for lumbar discectomy, anterior cervical discectomy and fusion (ACDF), lumbar posterior decompression and fusion. Examination of the lumbar spine revealed right paravertebral muscular tenderness. He could bend forward to the mid-lower leg level. X-rays of the pelvis revealed a normal study while x-rays of the lumbar spine showed L4-L5 laminectomy. diagnosed lumbar herniated disc, lumbar sprain/strain and lumbago. He prescribed Lidoderm patch and recommended cortisone injection to the spine and conservative treatment. He stressed the need for proper body mechanics. He recommended implementing home exercise program (HEP) and ordered lumbar MRI with and without contrast.

On September 9, 2013, MRI of the lumbar spine with and without contrast revealed: (1) Intervertebral disc space height was preserved with moderate to diffuse disc desiccation and there were scattered endplate Schmorl's nodes. (2) At L2-L3, mild ligamentum flavum hypertrophy with disc bulging. There was adequate capacity in the canal and foramina. (3) At L3-L4, there was ligamentum flavum hypertrophy with osteophytic ridging and disc bulging asymmetric to the left producing mild canal and moderate foraminal stenosis. (3) At L4-L5, there was facet arthrosis and ligamentum flavum hypertrophy with osteophytic ridging and disc bulging asymmetric to the right. There was an overlying focal 4 mm disc protrusion behind the upper endplate of L5. It produced moderate to moderately severe right lateral recess and foraminal stenosis in the setting of moderate canal

stenosis. There was deformity of the lamina on the right consistent with laminotomy with enhancing epidural fibrosis in the lateral recess on the right. (4) At L5-S1, there was mild disc bulging or shallow central disc protrusion without focal neural impingement or canal or foraminal stenosis.

On September 20, 2013, noted ongoing lower back pain mainly on the left side. The pain was described as sharp. The pain radiated into the left buttock and posterior thigh. Crossing his left leg over the right leg was painful. Getting in and out of chair was painful. Standing up after sitting for prolonged period of time caused significant back pain. reviewed the MRI findings and diagnosed lumbar herniated disc, lumbar radiculopathy and lumbar sprain. He prescribed Mobic and Lortab and offered the patient a left L4-L5 transforaminal epidural injection with selective nerve root block for diagnostic as well as therapeutic purpose.

On October 22, 2013, performed left L4-L5 transforaminal epidural injection with epidurogram and left L5 selective nerve root injection.

On November 11, 2013, noted 10% improvement in the back pain but no help for the leg pain. Examination of the lumbar spine revealed discomfort with range of motion (ROM) especially getting up from a bent forward position. recommended continuing Lortab and Mobic. He recommended left L3-L4 transforaminal epidural injection and selective nerve root block. The patient was given prescription for aspirin, Vytorin and metoprolol.

On December 12, 2013, performed left L3-L4 transforaminal epidural injection with epidurogram and left L4 selective nerve root injection.

On January 3, 2014, noted more than 60% relief of the left leg radicular symptoms without any change to his lumbar pain which continued to be the primary source of pain. The patient had a hard time standing from a seated position and propelled himself forward by the use of armrest. The lumbar spine had guarded movements that exacerbated on rotation and extension and tilt. There was tenderness of the paraspinal muscles and decreased left Achilles reflex. assessed lumbar sprain, lumbago, lumbar radiculopathy and lumbar herniated disc. He recommended lumbar facet block.

On January 30, 2014, performed bilateral L5-S1 facet injection.

On February 17, 2014, noted ongoing low back pain. noted that the patient had not been helped with physical therapy (PT), lumbar facet block, lumbar ESI, modification of activities etc. Examination showed right paravertebral muscular tenderness. diagnosed lumbago, lumbar herniated disc and lumbar sprain/strain. He noted that the facet blocks helped the patient 70% of the lower back pain. recommended lumbar discogram to better evaluate where the back pain was coming from.

Per utilization review dated February 24, 2014, the request for lumbar discogram was denied with the following rationale: *"The patient is a male who reported an*

injury to his low back when he was pushed down a set of stairs. The MRI of the lumbar spine dated September 9, 2013, revealed a previous right-sided laminotomy at L4-L5. Hypertrophic changes and a disc bulge were noted contributing to a moderately severe lateral recess and foraminal stenosis specifically on the right. The clinical note dated February 17, 2014, indicated the patient stating the initial injury occurred on xx/xx/xx. The patient reported a sharp lumbar pain that was constant. The patient rated the pain as 5-8/10 at that time. Bending forward objects and prolonged sitting all exacerbated the patient's pain. Upon examination, tenderness noted at the right paravertebral musculature. Absent reflexes were noted at both patellar and posterior tibialis regions. Diminished reflexes were noted at the left Achilles. The patient was recommended for a discogram of the lumbar region. The request for a lumbar discogram is non-certified. The documentation submitted for review elaborates the patient complaining of ongoing low back pain with associated reflex changes noted in the lower extremities. The Official Disability Guidelines do not recommend the use of a discography as there is minimal justification for performing these studies and the reproduction of the patient's specific back complaints on injection are of limited diagnostic value. Given this, the request does not meet guideline recommendations."

On February 26, 2014, noted ongoing constant and sharp lumbar pain and left leg radicular symptoms. The patient stood up from a seated position slowly and guarded limited by stiffness and pain that exacerbated with extension, tilt and rotation. There was tenderness of the paraspinal muscles. The lower extremities were more intact with some hyperesthesias along the left posterior lateral thigh and lateral lower leg. There was a positive left SLR test and a decreased left Achilles reflex. opined that the reason why a lumbar discogram was requested was to evaluate the possibility of additional areas that might be triggering symptoms. The patient had attempted and failed multiple forms of conservative treatments including medications, modification of activities and epidural injection and facet blocks. recommended appealing the denial.

Per reconsideration review dated March 11, 2014, the appeal for lumbar discogram was denied, with the following rationale: *"The patient is a male who reported an injury to his low back when he was pushed down a set of stairs on xx/xx/xx. The MRI of the lumbar spine dated September 9, 2013, revealed a previous right-sided laminotomy at L4-L5. Hypertrophic changes and a disc bulge were noted contributing to a moderately severe lateral recess and foraminal stenosis specifically on the right. The clinical note dated February 17, 2014, indicates the patient stating the initial injury occurred on xx/xx/xx. The patient reported a sharp lumbar pain that was constant. The patient rated the pain as 5-8/10 at that time, bending forward, lifting objects and prolonged sitting all exacerbated the patient's pain. Upon examination, tenderness was noted at the right paravertebral musculature. Absent reflexes were noted at both patellar and posterior tibial regions. The more recent office note February 26, 2014, reveals diminished reflexes were noted at the left Achilles. Furthermore there is hyperesthesia in the left posterior lateral thigh. argues that the discogram is to discern whether there are other pain generators. The request is for a discogram*

of the lumbar region but specific levels were not identified. states the previous review was based on a 12-year old literature but does not provide any more recent literature to support the use of discography. ODG clearly cites more recent literature from 2009-2012 to refute the use of discography. The patient has had previous laminectomy at L4-L5. The patient has left-sided symptoms. was not available and I left my number at 1154 hours March 7, 2014. No call back was received by the time of this submission on March 11, 2014."

On March 12, 2014, evaluated the patient for ongoing lumbar pain and left leg radicular symptoms. Examination of the lumbar spine showed the patient standing up from a seated position slowly and guarded. The lumbar spine had guarded movement that exacerbated with extension, tilt and rotation. There was tenderness of the paraspinal muscles and lumbar sacral region. The lower extremities continued to have hyperesthesias along the left posterior and lateral aspect of thigh and lateral aspect of lower leg. There was positive left SLR test and a diminished left Achilles reflex. submitted for an IRO on the previously requested lumbar discogram.

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

This claimant reportedly had a work incident on xx/xx/xx, when he fell on his buttocks and had low back pain. A subsequent MRI was completed on June 12, 2013, of the lumbar spine without contrast. There had been a previous spine surgery per the clinical history this surgery had been done approximately ten years before. This MRI showed, by report, degenerative changes at L2-L3 to the L5-S1 level. There were postoperative changes at L4-L5 with probable epidural fibrosis. At L5-S1, there was a 3 mm disc protrusion centrally.

noted the patient's history on August 1, 2013, and that the patient on examination had paravertebral tenderness on the right. proposed a lumbar MRI with and without contrast which was then completed on September 9, 2013. This study showed L3-L4 to have facet hypertrophy as well as ligamentum flavum hypertrophy. Disc bulging was noted causing narrowing of the neural foramen. At L4-L5, there was also facet arthrosis and asymmetrical disc bulging to the right. There was a 4 mm disc protrusion behind the upper portion of L5 with narrowing of the right lateral recess. At L5-S1, there was disc bulging and a shallow disc protrusion, but no focal nerve root entrapment.

then proposed a transforaminal injection first at L4-L5 which was completed on October 22, 2013, with only a 10% improvement reported on subsequent office visit of November 11, 2013. On December 12, 2013, then performed a left L3-L4 transforaminal injection and noted a 60% improvement of the left leg symptoms as of January 3, 2014. However, also proposed bilateral facet injections at L5-S1 which were then completed on January 3, 2014. on February 17, 2014, recommended a lumbar discogram to better evaluate the pain generator for the back pain. This request was sent for preauthorization and was reviewed for pre-certification with a neurosurgeon as well as. It was denied as a medical necessity.

Synopsis: The Official Disability Guidelines does not support the utilization of discography for the definition of the pain generator as it is a subjective test which has not been validated to be objective or medically necessary. Moreover, this patient has not had any type of psychological assessment regarding his pain behavior.

The patient has radicular pattern and has multilevel involvement of the lumbar spine from L2-L3 distally with degeneration consistent. Please note that the flexion-extension radiographs taken on September 20, 2013, did not show any lumbar spine instability. Thus, the patient does not qualify for even a spine fusion operation. The medical necessity for proceeding with discography is not supported by the ODG and evidence-based literature in this patient's workup and care. The request is inconsistent with evidence-based medicine and specifically the ODG.

INFORMATION PROVIDED FOR REVIEW:

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES