

# Medical Assessments, Inc.

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## Notice of Independent Review Decision

March 10, 2014

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Outpatient Lumbar L4-5 discogram with CT

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

The Reviewer is a Board Certified Orthopaedic Surgeon with over 42 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:**

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was injured in xxxx, as a result of a slip and fall on the job. It was reported he was walking and slipped. He did not completely fall, but he jerked his body in an attempt to avoid falling. There was a 1995 back surgery/laminectomy prior to the date of injury. Treatment has included physical therapy, medication, multiple injection, and at least 15-20 facet rhizotomies in the low back and SI joints.

09/10/1997: MRI of the Lumbar Spine with and without Gadolinium. Impression:  
1. L3-L4 normal MRI. 2. L4-L5 a combination of chronic disc protrusion, central/left par central with ventral theca sac effacement, and enhancing fibrosis.

Status post left laminectomy. 3. L5-S1 negative for disc herniation or compressive disc disease. Bilateral facet arthropathy.

06/21/2002: Evaluation. On physical examination there is tenderness to palpation in the bilateral lumbar paraspinals. Lumbar range of motion is decreased in all planes. There is no significant neurological deficit noted in the bilateral lower extremities. His strength and sensation as well as deep tendon reflexes are intact and symmetrical. The physical examination continues to be consistent with the diagnoses of degenerative disease of the lumbar spine and myofascial pain in the lumbar paraspinals.

07/18/2003: Evaluation. Since claimant was last seen, he has continued to receive some facet rhizotomies periodically. He was last seen on 06/21/02 and in September he had a right sacroiliac joint rhizotomy. He reported that the procedure was quite helpful to him. In October, he had some facet blocks which were not helpful. In December, he had bilateral rhizotomies of the lower lumbar facets and a right sacroiliac rhizotomy. Reported quite helpful. The claimant reported that this pain has been controlled by that procedure up until the present time. Claimant continues to do well with facet rhizotomies 1-2 times per year and S1 joint rhizotomies as well. Procedure keeps his pain under control and allowed him to keep working with very little medication usage in addition to the procedures. The claimant has not gotten much benefit out of any sort of nerve blocks other than the facet rhizotomies and those sorts of treatments should be considered unreasonable and unnecessary in this case. Medications: Lortab.

03/30/2012: Therapeutic drug monitoring. Claimant reported doing well most of the time. Reported he has gone by taking 0-2 pain pills per day. He reported it is possible that he had not taken any for a day or two when drug screen was ordered. Medication: Hydrocodone 10/325mg. Assessment: Lumbago. Lumbar spondylitis without Myelopathy. Postlaminectomy syndrome. Plan: Refill meds at 1-2 per day for 60 day supply.

10/29/2012: Therapeutic drug monitoring. Assessment: Sacroilitis bilateral, Lumbar spondylosis without myelopathy. Plan: schedule lumbar facet epidural steroid injection, bilateral.

02/08/2013: Evaluation. Claimant reported 80% pain relief. 100% for 2 weeks. Complained of pain right SL area, not tender to palpation. Assessment: Post laminectomy syndrome (lumbar), (Failed Lumbar Back Syndrome). Plan: Scheduled for follow-up, refill medications.

06/20/2013: Re-evaluation Pain/Medications. Follow-up: Complained of bilateral sacrothac joint (SI) pain and severe pain both SI joints. SI injections gave good pain relief- short-term. Sitting increases pain. Mowing lawns increases pain. No lower back pain. Norco is not lasting 3-4 hours. Point tenderness- SI joint bilaterally. Assessment: Sacroibutus Bilateral, Postlaminectany Syndrome (lumbar), (Failed lumbar back syndrome). Plan: Phizotomy, bilateral Sacroiliac

joint- if not, SI injection. Roxicodone 1.5 mg tabs, Discontinue Norco, Roxicodone 15mg, follow progress Roxicodone 15mg.

08/05/2013: Evaluation. Claimant has been having severe pain in the SI area of the lumbar spine. Claimant cannot walk or sit for long without pain becoming so severe he had to try to shift to a position of comfort. After sitting the pain goes down the posterior thigh to just above the knee. Has noted after sitting for long periods the posterior thighs becomes numb. Has had to alter his work as his job requires he drive and he is finding this impossible. Has tried PT before with little long term relief. Has been using heat daily to get some relief after having to walk for any distance. Has been taking pain pills for short term relief. Has taken anti-inflammatories. Greatest and longest relief is from the SI Rhizotomy done in June of 2012. He had 70% improvement for three months after the injection and feels the pain remained more in the low back than to the SI area until June of 2013. Now reports the pain is intense again. Claimant present with history of SI joint Rhizotomy. Current Medications: Alprazolam 0.25mg tab, Roxicodone 15mg tab, Skelaxin 800mg tabs. Physical Findings: Lumbar/Lumbosacral Spine: Lumbosacral spine exhibited tenderness on palpation. Lumbosacral spine exhibited tenderness on palpation of the spinous process. Sciatic notch on the right exhibited tenderness on palpation. Sciatic notch on the left exhibited tenderness on palpation. Lumbosacral spine exhibited spasms of the parasoinal muscles bilaterally. Lumbosacral spine did not demonstrate full range of motion. Lumbosacral spine flexion was abnormal. Lumbosacral spine extension was abnormal. Lumbosacral spine rotation to the left was abnormal. Lumbosacral spine rotation to the right was abnormal. A straight-leg raising test of the right leg was positive. A straight-leg raising test of the left leg was positive. Pelvis: Right sacroiliac joint showed tenderness on palpation. Left sacroiliac joint showed tenderness on palpation. Assessment: Sacroiliac Bilateral, Lumbargo (Intractable Pain Syndrome), Lumbar spondylosis Without Myelopathy, Lumbar postlaminectomy syndrome, (Post Laminectomy Syndrome Lumbar. Plan: Precert procedure- Bilateral SI Rhizotomy, Start Skelaxin ½ to 1 per muscle spasms.

10/05/2013: MRI. Impression: 1. Left laminectomy at L4-L5. The L4-L5 disk is dehydrated and narrowed. 1.7 mm generalized annular disk bulging is present. No extruded disk fragment present. 2. Right neural foraminal stenosis at L4-L5 is present. 3. Slight 1.2 mm disk bulging at L5-S1. 4. Bilateral facet arthropathy at L5-S1. 5. Lumbar spine otherwise negative.

10/21/2013: Evaluation. **Physical Exam:** Claimant has a well-healed incision at the L4-5 level. Flexion extensions are limited. He can heel toe rise normal. Reflexes are symmetrically diminished. EHL and TA reveals weakness of the left extensor hallucis straight leg raising is productive of low pain bilaterally and Faber for slightly in the right lower back. Sensation light touch is within normal limits. He is tender not only in the midline, but also laterally of the iliac crest. **Radiology/Imaging Review:** X-Ray review: Plan x-ray show that there is asymmetric collapse at the L4-5 level on the right there is also tilting of the L5-S1. The disc spaces from L3, 4 proximal and appeared to be normal. There is no

instability with flexion and extension. He does have an enlarged transverse process on the left L5 level it is difficult to determine if there is an articulation there. There is a left-sided laminectomy at the L4-5 level. **MRI review:** MRI scan from October 5, 2013 shows a markedly degenerative disc at the L4-5 level. There appears to be no significant canal compromise, although the quality of the MRI scan is fair. It appears that there may be a laminectomy at the left L4, 5 level. The other disc is normally hydrated. **Assessment:** Chronic low back pain and since on the job injury xxxx, status post previous lumbar laminectomy, left L4-5, rule out post laminectomy syndrome with normal disc above and below as per MRI scan, status post extensive conservative treatment including multiple injections, as well as rhizomies in the low back as well as of the S1 joint and medications. **Plan:** Recommended him to undergo a lumbar discography only at L4-5 level. If indeed this reproduces this pain then he would be a candidate for a stabilization procedure at that level only.

11/05/2013: Behavioral Medicine Evaluation. Medications: Sertraline, Oxycodone 1-2 per day, Metaxalone. General Conclusions: Major Psychological Symptoms: low level anxiety, sleep disturbance. Psychosocial issues should not impact the outcome of the discogram nor of any potential surgery. Continues to work, had good response to previous spine surgery. Some underlying anxiety. Continue Sertraline for the foreseeable future. Medical Treatment Recommendations and Client Management Suggestions: Based on this the Clinical Health Psychology evaluation he is clear for the discogram with no concern that psychosocial issues will influence results. Based on this presurgical psychological screening, the patient is clear for spine surgery with a good psychosocial for pain reduction and functional improvement.

12/05/2013: Evaluation. Claimant reports continued pain in low back. Reports it as a burning sharp pain that gets worse with movement. Can find position of comfort by lying down or sitting but pain is intense with any movement. Denies any help from exercises. Has had numerous injections and rhizotomy that helped for short time. Reports the intensity of his pain is progressively getting worse. Has seen a back surgeon who did new diagnostic that shows right L4-5 neural foraminal stenosis and disc bulge at L4-5, has requested a L4-5 discogram with CT. Exercises do not help pain and has tried anti-inflammatories without significant relief. The claimant has been utilizing Roxycodone 15mg for breakthrough pain. 1-2 per day. The claimant is currently taking Skelaxin. Current Medications: Amlodipine Besylate 5mg, Aspirin, Jalyn 0.5mg, Nexium 40mg, Sertraline HClmg. Lumbar/Lumbosacral Spine: General /bilateral: Lumbosacral spine exhibited tenderness on palpation. Lumbosacral spine exhibited tenderness on palpation of the spinous process. Right side of the lumbosacral spine exhibited tenderness on palpation of the transverse process. Left side of the lumbosacral spine exhibited tenderness on palpation of the transverse process. Sciatic notch on the right exhibited tenderness on palpation. Sciatic notch on the left exhibited tenderness on palpation. Lumbosacral spine did not demonstrate full range of motion. Lumbosacral spine flexion was abnormal. Lumbosacral spine extension was abnormal. Lumbosacral spine

rotation to the left was abnormal. Lumbosacral spine pain was elicited by motion. A straight-leg raising test of the right leg was positive. A straight-leg raising test of the left leg was positive. A Patrick-Fabere test was positive at the right side of the sacroiliac joint. A Patrick-Fabere test was positive at the left side of the sacroiliac joint. Pelvis: Right sacroiliac joint showed tenderness on palpation. Left sacroiliac joint showed tenderness on palpation. Assessment: Lumbago (Intractable pain syndrome), Lower back pain, Lumbar radiculopathy, (Lumbar radiculitis), Lumbar postlaminectomy syndrome(Post Laminectomy Syndrome Lumbar). Plan: Precert procedure: Lumbar 4-5 discogram with CT.

12/16/2013: UR. Rationale for Denial: The claimant was injured back in xxxx. He was injured when he slipped. There was a 1995 back surgery/laminectomy prior to the date of injury. The nurse practitioner notes low back pain intense is with any movement. He had numerous injections and rhizotomy that helped for a short time. The pain is getting worse. A back surgeon requested the discogram. The ODG are not supportive of discography. At present, based on the records provided, and the evidence-based guideline review, the request is not certified.

02/12/2014: UR. Rational for Denial: It is the opinion of the reviewing physician that, "The claimant complains of low back pain. The claimant did undergo laminectomy at the L4-5 level. Most recent MRI 10/05/2013 showed left laminectomy at L4-5, L4-5 disc was dehydrated and narrowed, generalizing Lumbar disc bulging is present; no disc fragment is noted; right neural foraminal stenosis at L4-5 is present. The claimant has undergone multiple procedures including lumbar epidural steroid injections, physical therapy, lumbar CT myelogram as well as rhizotomies on L3-S1; the last one was done 01/25/2013. Joint injections were done also to give the patient short term relief. requested the L4-5 discogram for possible fusion. Straight leg raises was positive bilaterally, Patrick/FABRE test was positive bilaterally; there was diminished sensation on the right lateral calf to the lateral side of the foot. also originally said the claimant was from a psychological standpoint a good candidate for the discogram. Per the Official Disability Guidelines they are not supportive of discography. There is a lack of diagnostic quality at the L4-L5, particularly the single level of provocative discography. Studies have suggested that reproductions of patient's specific back complaints, injection is at limited diagnostic value. There is also no request for control, to compare, to the L4-5 level. Therefore, the utilization for provocative lumbar discography is not supported per ODG.

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

The previous adverse determinations are upheld. Based on findings in the records and ODG, a discogram is not indicated. The claimant has had prior surgery and a degenerated disc at the L4-5 level. The discogram would obviously be abnormal and would not help with the diagnosis or treatment. Therefore, the request for Outpatient Lumbar L4-5 Discogram with CT is not medically necessary.

## 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)**