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Notice of Independent Review Decision

March 3, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L2-L3, L3-L4 and L4-L5 discogram

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

Diplomate American Board of Orthopaedic Surgery
Fellowship Trained in Spine Surgery and Foot and Ankle Surgery

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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ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who suffered a low back injury on xx/xx/xx. He was lifting when he felt pain to his back.

Pre-injury records

1990 – 1992: On September 4, 1990, evaluated the patient for the right hand pain. The patient was injured in a motor vehicle accident (MVA) on xx/xx/xx. He stated that his car ran into a light post and he had immediate pain in his neck, back and right hand region. He also had occasional numbness in his hand that radiated into the arm. He also complained of pain, particularly with holding or

grasping objects. He also had difficulty on touching the thenar region. X-rays were unremarkable. diagnosed chronic right hand and wrist sprain with possible carpal tunnel syndrome (CTS). He recommended physical therapy (PT) for wrist and placed the patient on an anti-inflammatory medication. The scan documents are illegible.

From December 18, 1990 through September 18, 1991, treated the patient with procedure to include carpal tunnel release (CTR) of the right wrist as well as ulnar nerve release of the right wrist. Postoperatively, he recommended starting PT.

On September 18, 1991, opined that the patient had reached maximum medical improvement (MMI) with 36% whole person impairment (WPI) rating. The scan records are illegible.

On February 22, 1992, performed a medical evaluation and rendered the following opinions: The patient had been fired from his work. He was suitable for work. The patient should however, look for a less repetitious job and perhaps try to get a job in construction rather than on the assembly line. He was not tolerant of repetitious activities, but the patient could use his hands for manual labor as long as the overload was not excessive. Impairment rating was 12%.

1993 – 1996: Records are not available.

Post-injury records

1997 - 2001: On xx/xx/xx, evaluated the patient for low back pain. Examination of the lumbar spine showed swelling or ecchymosis. There was midline tenderness in the lumbosacral junction. Straight leg raise (SLR) was 60 degrees on the right side. X-rays of the lumbar spine were unremarkable. recommended continuing Motrin. He recommended discontinuing Valium. The patient was to undergo PT and start Soma. He was to use back brace and Thera-Gesic cream and cold pack.

On August 14, 1997, the patient underwent imaging studies of the lumbar spine at the Imaging; however, the scan documents are illegible.

On September 8, 1997, evaluated the patient for ongoing low back pain on the right side with a pulling sensation. diagnosed low back pain, bilateral lumbosacral radiculopathy, left more than right and degenerative disc disease (DDD) with a herniated component at L4-L5 and to L5-S1. The scan documents are illegible.

On October 11, 1997, a neurosurgeon evaluated the patient for low back pain with radicular pain down both lower extremities to the calves. The patient also had numbness and tingling to the right toes that occurred occasionally. The patient had been referred for a second opinion. The patient was recommended surgical intervention. The scan documents are illegible.

On November 13, 1997, the patient underwent lumbar steroid epidural injection epidurogram.

The scan document report dated May 20, 1999, is illegible.

The scan document report dated July 19, 1999, is illegible.

On January 12, 2000, the patient underwent surgery. Surgical procedure included transforaminal lumbar interbody fusion L5 to S1, bilateral lateral transverse process fusion L5-S1, segmental spinal fixation L5 to S1, prosthetic replacement L5 intervertebral disc with titanium mesh and bone graft from right posterior iliac crest. The scan documents are illegible.

On February 21, 2000, evaluated the patient for a failed low back syndrome at the L4 level as well as DDD at L5 level. However, the scan record is illegible.

There was a functional capacity assessment report dated July 13, 2000, however, the record is illegible.

On July 18, 2000, evaluated the patient for evaluation of admission into the rehabilitation treatment. It was noted that the patient did not feel better from the surgery and began to experience difficulties. He had two subsequent surgeries. He was found to be an appropriate candidate to participate in an interdisciplinary pain rehabilitation program.

On August 8, 2000, noted that the request for a pain management program had been denied. recommended PT.

On November 18, 2000, the patient underwent isolated nerve root blocks at L4-L5 and L5-S1 on the left side followed by lumbar epidural steroid injection (ESI).

2001: On January 6, 2001, the patient underwent isolated nerve root blocks at L4-L5 and L5-S1 on the left side.

2002 – 2004: Records are not available.

On March 03, 2005, noted the patient was a candidate for a spinal cord stimulator (SCS) to treat his persistent and chronic pain.

On April 13, 2005, noted constant left leg 7-8/10 pain with continued intake of unknown quantities of Hydrocodone. The patient had an antalgic gait with decreased range of motion (ROM). The patient had normal strength in the lower extremities, perhaps some weakness of the extensor hallucis longus (EHL) but difficult to fully evaluate. There was positive straight leg raising (SLR) in the left lower extremity at about 20 degrees. assessed low back pain and left lower extremity pain and discomfort secondary to the post-laminectomy syndrome versus failed back syndrome and S1 radiculopathy by history and physical examination. He ordered psychological testing in preparation for spinal cord stimulator (SCS) trial.

On October 20, 2005, a clinical psychologist recommended six sessions of cognitive behavioral therapy.

Per DWC 73 dated October 24, 2005, the patient was evaluated.

On November 22, 2005, performed permanent SCS implantation after a successful trial.

2006: On September 25, 2006, the patient reported non-healing or difficult healing cuts status post SCS implant on ipsilateral side. He also had two new shin lesions under left underarm and left thigh. Diagnosis was new papular lesions shin x2 benign in appearance. referred the patient to a dermatologist and recommended work up for diabetes mellitus.

2007: On February 19, 2007, the patient returned to on a follow-up visit status post SCS placement. He complained of spots on arm. scheduled the patient for reprogramming of his SCS.

On June 11, 2007, noted the patient's pain was stable with SCS. He recommended SCS reprogramming.

On June 14, 2007, the patient continued with left leg pain. noted a rash in patient's left palm that patient attributed to SCS allergy. recommended turning SCS off and trying a course of Lyrica for the leg pain.

On August 29, 2007, noted the patient continued to have problems with a rash in his hand. Hydrocodone did not help as much and it was changed to Tramadol. Neurontin and Lyrica were of no benefit. Cymbalta had alleviated his pain in the past. recommended allergies testing with the help of a kit available from Metronics and that was to be done office.

On September 24, 2007, saw the patient for ongoing complaint of chronic low back pain. Aggravating conditions included standing or being sedentary for long periods. Alleviating conditions included walking, changes in position and being active or stretching. He had 25% back pain and 75% left leg symptoms. X-rays of the lumbar spine showed laminectomy at L3 and L4 and fusion of L5-S1. Diagnoses were lumbago, lumbar radiculopathy and lumbar spondylosis. recommended maintaining proper body mechanics, no heavy lifting. The patient was to follow-up with his pain management doctor for symptomatic relief.

2008: On February 4, 2008, noted the patient was utilizing more hydrocodone. opined that the patient might benefit from a peripheral nerve stimulator than SCS.

Per utilization review dated April 23, 2008, the request for lumbar ESI was denied.

On April 28, 2008, noted that approximately one month ago the patient twisted his back when he stepped in a hole while walking in the park. Since that time, he had severe pain and discomfort in his back. X-rays of the lumbar spine showed a

spontaneous fusion of L3 to L4 secondary to a large anterior osteophyte. There was a solid fusion at L5 to S1. There was narrowing of the L4 intervertebral disc with what appeared to be a retrolisthesis of L4 on L5. He ordered a computerized tomography (CT) scan to evaluate L3-L4 and L4-L5 levels.

On June 23, 2008, reviewed the CT scan performed on May 13, 2008, that revealed L3-L4 was not completely fused. recommended the patient to undergo injections.

On August 13, 2008, performed an injection of the screw heads under fluoroscopy.

On September 22, 2008, noted the patient had improvement in the pain.

On September 22, 2008, noted complete pain relief with hardware block lasting several weeks and he recommended hardware removal.

On November 7, 2008, noted the patient had continued having terrible back pain. noted the patient was taking Lortab for pain. He recommended a posterior lumbar hardware removal.

On November 24, 2008, the patient reported pain since the SCS was implanted and he wanted it to be removed. recommended follow-up to discuss removal of the cable from his stimulator.

2009: On January 20, 2009, performed removal of the SCS.

On February 23, 2009, noted the patient was extremely emotional due to the chronicity of his pain. The patient reported that SCS removal did not help his pain. referred the patient for **psychological** evaluation. He also prescribed Cymbalta and a hardware block.

On April 08, 2009, performed injection at the head of the screws status post lumbar laminectomy fusion procedure.

On May 21, 2009, the patient reported complete pain relief for one week but the effect of the injection then wore off and his pain had returned. recommended hardware block.

On August 20, 2009, noted that an ESI request was denied. The patient had begun an exercise program that had helped his pain. The patient was to continue with his exercises activities.

On November 19, 2009, performed a peer review and noted the following: *“On February 15, 2001, the patient was released for job retraining. He had obtained 70% pain relief with nerve root blocks but symptoms had returned. On May 24, 2001, the patient had returned to work-full time. He was felt to be at MMI. He had similar symptoms but felt he was slowly improving. On November 19, 2001, the*

patient was having left lower extremity cramping and he was prescribed Skelaxin. On May 7, 2002, did a peer review and agreed with intermittent use of Vicodin and Skelaxin and noted this type of medication on an intermittent basis would be a life-long requirement. On October 31, 2002, noted Hydrocodone was medically necessary to treat his chronic persistent pain. On November 14, 2002, repeated his opinion that narcotics should be used intermittently, as well as, Skelaxin. His employer should be notified of his narcotic use because of possible harm to himself and others in the work place. The same applied to driving. On January 30, 2003, he was noted not to have low back pain. He continued to have left leg pain which became worse after 8-12 hours of work and Neurontin was prescribed. On May 17, 2003, he was receiving Ambien and Vioxx for his constant low back pain and left leg pain. On November 14, 2004, there was a treatment gap of 18 months. The patient had been in a car he was riding in bottomed out when it went over a bump causing him low back pain. X-rays revealed a solid L5-S1 fusion, there was L3-L4 anterior osteophytes that was felt had been irritated and he was returned to work and released. On December 14, 2004, did a peer review and noted that a physical examination had not been done in any of the numerous post op encounters. Based on the lack of available diagnostic tests and exams to evaluate his persistent pain (adjacent disc disease and EMG for damaged nerve roots) and based on his return to work, further medical treatment was not deemed medically necessary. He agreed with recommendations and felt that surgical treatment had been based on pre-existent degenerative disc disease. On March 3, 2005, noted the patient was a candidate for a SCS to treat his persistent, chronic pain. On May 23, 2005, the patient was prescribed Ativan and Zonegran instead of Neurontin. On August 17, 2005, felt the SCS trial was reasonable. He recommended the patient should also continue to work as a deliveryman but with a 20-pound lifting restriction. On October 24, 2005, noted Cymbalta in the morning obviated need for narcotics during the day except at night. Despite his high pain levels, his pulse rate remains within normal limits. On May 25, 2006, the patient continued with left leg pain despite SCS. Pulse was 72. did not do a physical examination to evaluate patient complaints of left pain and swelling. On January 26, 2006, (This is a typographical error) the patient was taking Hydrocodone three times a day. stated this was less than before SCS implantation. However, this could not be evaluated because he didn't document the amount of narcotics taken before the SCS surgery." In response to the questions, he rendered the following opinions: (1) Office visits and non-invasive pain management were medically necessary. (2) Opioids were not recommended. (3) The patient could return to light physical demand level (PDL). He could lift/carry 20 pounds, push/pull 35 pounds, overhead lift 15 pounds, and walk 8 hours with ability to change positions as necessary for pain.

On December 21, 2009, noted the patient continued to have the same pain and discomfort. The patient reported that the dorsal column stimulator did seem to be working fairly well. He was still taking hydrocodone. recommended evaluation from a pain management standpoint.

2010: On February 16, 2010, evaluated the patient for ongoing low back pain and left lower extremity pain even though he had two spine surgeries. His pain level

was 7/10 and it was described as aching, throbbing, and numbness and constant in nature. He was utilizing hydrocodone, Xanax, insulin and Lipitor. Diagnosis was lumbar back pain syndrome, lumbar radiculopathy, lumbar post-laminectomy syndrome, chronic intractable pain syndrome and chronic opioid use. recommended discontinuing hydrocodone and starting the patient on OxyContin, Dilaudid, Senokot and amitriptyline. The patient underwent a urine drug screen which was positive for hydrocodone, hydromorphone, and alpha-hydroxyalprazolam.

On March 23, 2010, the patient reported having good pain relief with OxyContin and hydromorphone. He continued to have pain to the lower back as the instrumentation caused severe symptomatology. referred the patient for chronic pain program and prescribed transcutaneous electrical nerve stimulation (TENS) unit. The patient underwent a urine drug screen which was positive for hydromorphone, oxycodone, oxymorphone and alpha-hydroxyalprazolam.

On follow-up in April, refilled OxyContin and Dilaudid.

On April 14, 2010, a urine drug screen was found to be positive for hydromorphone, oxycodone, oxymorphone and alpha-hydroxyalprazolam.

On May 12, 2010, noted that OxyContin and Dilaudid were helping. The patient was noted to have severe problems with anxiety and depression secondary to chronic pain syndrome. He prescribed Pristiq, refilled medications and referred the patient for psychological treatment for acupuncture and for massage therapy.

On May 12, 2010, a urine drug screen was performed and it was positive for hydromorphone, oxycodone, oxymorphone and alpha-hydroxyalprazolam.

Per May 14, 2010, Massage therapy progress note, the patient was recommended continuing treatment for two sessions a week for six weeks.

On June 15, 2010, noted the patient was doing better on hydrocodone than Dilaudid and wanted to switch back to that. placed the patient back on hydrocodone. A urine drug screen was positive for hydromorphone, oxycodone, oxymorphone, hydrocodone, tramadol and alpha-hydroxyalprazolam.

On June 30, 2010, a licensed psychologist, evaluated the patient and assessed pain disorder associated with both psychological factors and medical condition and recommended six weekly individual pain management based psychotherapy sessions and review of antidepressant regimen.

From July 13, 2010, through September 7, 2010, the patient underwent multiple sessions of individual psychotherapy under the care.

On July 26, 2010, noted the patient continued to have pain and discomfort in his back. was concerned about the patient not having appropriate pain medications

and referred the patient to his primary care physician (PCP) for pain medications as needed. He opined that no further refills would be given for pain medications.

On September 23, 2010, the patient underwent magnetic resonance imaging (MRI) of the lumbar spine.

On September 27, 2010, noted that the patient had a lumbar MRI that depicted adjacent pathology over the L4-L5 region. Unfortunately, over the weekend he had a flare-up of lumbar pain for which he had to report to the emergency room (ER) for treatment. He was evaluated and discharged with instructions to follow-up. On examination, he had a very limited painful range of motion (ROM) of the lumbar spine, decreased sensation along the posterior aspect of the lower leg as well as the medial and plantar aspect of the left foot and a positive left SLR test and a diminished left bilateral Achilles reflexes. Diagnosis was lumbar radiculopathy, lumbar spondylosis and lumbago. The patient was noted to have symptomatic hardware. He was recommended to continue maintaining proper body mechanics and avoiding heavy lifting and doing some stretching.

On September 29, 2010, reviewed the lumbar MRI performed on September 23, 2010, that showed an L5-S1 anterior fusion, desiccation at the L3-L4 and L4-L5 discs; facet hypertrophy of L4-L5 causing neural foraminal stenosis on the left side. recommended a lumbar MRI with and without contrast to see if the patient has epidural scar. A lumbar discogram was indicated to see if he had discogenic pain. If he had a positive discogram, there was a 50% chance to help his low back pain. Most likely, the leg pain would not change for he had this for too many years.

On October 15, 2010, MRI of the lumbar spine with and without gadolinium enhancement showed the following findings: The patient had undergone laminectomy with interbody fusion graft L5-S1 with typical artifact from the pedicle screws. Vertebral body height and signal was otherwise well maintained. There was spondylosis L3-L4. The AP diameter of the canal at L4 was reduced at 13 mm. At L3-L4, there was facet arthrosis and ligamentum flavum hypertrophy with osteophytic ridging and disc bulging without significant canal or foraminal stenosis. At L4-L5, there was facet arthrosis and osteophytic ridging with mild canal stenosis. At L5, there was a typical artifact from pedicle screws which appeared in good position. At L5-S1, there was interbody fusion graft in good position. There were laminectomy changes with wide patency to the canal. No significant epidural fibrosis was seen. The neural foramina appeared adequately capacious in so far as they were seen. At S1, pedicle screws were in good position.

On October 15, 2010, MRI of the brain with and without gadolinium enhancement was normal.

On October 22, 2010, reviewed the MRI findings and recommended a left L4-L5 transforaminal epidural injection with selective nerve root block (SNRB). He also

opined that a lumbar discogram was indicated to see if the patient had a discogenic pain.

On November 30, 2010, performed a left L4-L5 transforaminal epidural injection with epidurogram and left L5 SNRB.

On December 16, 2010, noted the patient's left leg pain went away for almost nine days. However, the left lateral thigh pain was coming back. The injection did not help his low back pain. The patient was most likely having facetogenic pain from the level about his L5-S1 fusion. recommended a left L4-L5 transforaminal epidural injection with SNRB and an L4-L5 facet block.

2011 – 2012: On January 13, 2011, performed a right L4-L5 transforaminal epidural injection with epidurogram and right L5 selective nerve root injection.

On January 28, 2011, the patient reported having approximately 75% relief of the lower extremity radicular symptoms and about 40% relief of the back pain. The primary source of pain was the lumbar pressure that was constant and it exacerbated whenever the patient initiated movements or ambulation. He still had some numbness on the left dorsal foot. recommended proceeding with a facet block and to continue maintaining proper body mechanics and avoiding any type of direct heavy lifting.

On February 15, 2011, performed bilateral L4-L5 and L5-S1 facets injections.

On March 2, 2011, noted the patient had 100% relief of his lumbar pain within the first day. Unfortunately, that relief lasted for 10 days and his symptoms returned. recommended proceeding with a follow-up injection over the same area on the hopes to providing further help.

Per utilization reviews dated April 5 and April 6, 2011, the request for facet block injections at L4-L5 and L5-S1 as related to the lumbar spine was denied as ODG did not recommend multiple facet joint injections and moreover there was not sufficient documentation or rationale for a repeat facet block injections at L4-L5 and L5-S1.

On November 30, 2011, noted the patient continued to have constant lumbar pain and intermittent lower extremity radicular symptoms. He recommended maintaining proper body mechanics and avoiding heavy lifting. Ibuprofen, Skelaxin and tramadol were prescribed.

On February 28, 2012, noted that the patient's lumbar and radicular symptoms had progressively worsened over the past six weeks. The patient had significant neurological changes that were causing muscular atrophy as well as loss of reflexes and positive SLR. prescribed Skelaxin, ibuprofen, Lyrica and Lortab and recommended a lumbar MRI with and without contrast.

2013: On July 11, 2013, the patient reported that he had been able to control his symptom for several months with the use of acupuncture. However, over the last several months, the symptoms had continued to escalate and the acupuncture was no longer affective. X-rays of the lumbar spine demonstrated intact intervertebral cage at the L5-S1 with the full fusion. The lateralized facets of the L5 had effused posteriorly on the left. There was some facet arthropathy of the L4-L5 noted. Dynamic imaging of the lumbar spine demonstrated a facet gapping causing neural foraminal stenosis of the L4-L5 as it separated 6-mm between flexion and extension. Assessment was lumbago, lumbar radiculopathy and L4-L5 facet gapping. reported that the patient's lumbar pain and radicular symptoms had worsened over the past two months. The patient had received the prescription of a Medrol Dosepak as well as Skelaxin, Lyrica, and tramadol to help with his pain. He was encouraged to stay active, avoid heavy lifting, and most of all maintain proper body mechanics.

On July 29, 2013, the patient reported that the medication regimen had been highly effective. However, he continued to struggle with symptoms. recommended a follow-up lumbar MRI.

On September 4, 2013, MRI of the lumbar spine showed evidence of laminectomy with interbody fusion graft L5-S1. Pedicle screws at L5-S1 had been removed in the interval. There was residual postsurgical metallic susceptibility artifact. Vertebral body height was maintained in the interval since the prior study the patient had developed Modic type II changes L4-L5. There was disc desiccation at L3-L4 and L4-L5 in a pattern which was unchanged. There was anterior osteophyte at L3-L4. At L3-L4, there was facet arthrosis and ligamentum flavum hypertrophy with osteophytic ridging and disc bulging without significant canal or foraminal stenosis; this was unchanged in the interval. At L4-L5, there was facet arthrosis and osteophytic ridging with mild-moderate canal stenosis, unchanged in the interval. At L5, there were ghosts of pedicle screws which were removed in the interval. At L5-S1, the interbody fusion graft was in good position. There were laminectomy changes with wide patency to the canal. No significant epidural fibrosis was seen. The neural foramina appeared adequately capacious and were better seen with the interval removal of pedicle screws. At S1, there were ghosts of pedicle screws best appreciated on the sagittal T1 weighted images.

On September 16, 2013, reviewed the MRI of the lumbar spine and x-rays of the lumbar spine. He opined that despite multiple treatments, the patient had degeneration of his spine with notable internal disc derangement of L4-L5. The patient had had a laminectomy/discectomy at that level. However, lumbar discogram would help determine whether he had discogenic pain.

Per utilization review dated September 24, 2013, the request for an outpatient L2-L3, L3-L4 and L4-L5 lumbar discogram was denied with the following rationale: *"Official Disability Guidelines (Work Loss Data Institute. Web-based version) does not recommend discography, but also states, "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).” Provider has documented consideration for further lumbar surgery, and has indicated that results of discography will assist in decision on whether or not to proceed. ODG’s patient selection criteria if provider and payor agree to perform discography anyway are not met. A recent psychological evaluation is not documented, and therefore criteria for discography or fusion are not met. ODG would support single level testing with control. However, the current request is for testing of two abnormal appearing discs plus a control level. Non-authorization of this request is recommended.”

On October 2, 2013, saw the patient for ongoing low back pain. It was noted that the request for lumbar discogram had been denied. On exam, the patient stood from a seated position in a very slow guarded movement. The lumbar spine exacerbated with pain on extension rotation and tilt. There was tenderness of the paraspinal muscles in the lumbar sacral region. The lower extremities had a generalized decreased sensation on the right lateral thigh and bilateral lateral lower legs. There was a positive right SLR test and a positive right Patrick’s. A lumbar discogram was recommended in order to identify whether or not the patient was having discogenic symptoms. He was given prescription of tramadol and Lyrica.

On November 4, 2013, encouraged the patient to stay active, avoid heavy lifting and to maintain proper body mechanics.

Per reconsideration review dated November 4, 2013, the request for an outpatient L2-L3, L3-L4, L4-L5 lumbar discogram was denied with the following rationale: *“This male was injured on xx/xx/xx, while lifting. The patient does have prior history of interlaminar laminotomy L4-L5 with removal, herniated nucleus pulposus (HNP) L4-L5 and nerve root decompression at L5-S1 December 9, 1997. The patient had a lumbar procedure for an HNP March 1999 with subsequent permanent spinal cord stimulator placement November 25, 2005. The patient subsequently had a removal of the spinal cord stimulator January 20, 2009. Currently the patient had a repeat MRI of the lumbar spine on September 4, 2013, noting the L5-S1 fusion with laminectomy changes and endplate changes at L3-L4. On October 2, 2013 noted the patient reporting lumbar pain continuing to be a constant gripping factor that can change anywhere from 2-8 on a 10 scale. It was noted a prior request for lumbar discography had been denied. The physical examination noted the patient standing from a seated position, a very slow guarded movement. Extension, rotation tilting exacerbated the lumbar spine pain. Paraspinal tenderness was noted in the lumbosacral region. Generalized decreased sensation right lateral thigh, bilateral lower leg. Straight leg raising positive right with a positive Patrick’s test. Considerable muscle atrophy of the right leg was noted. The rationale for denial of the discogram was noted that ODG does not recommend discography but the doctor did not give her own personal opinion. Reconsideration for the discogram was requested. The recommendation is non-certification of the CT discography of the lumbar spine as ODG does not recommend discography noting in the past discography had been used for a preop evaluation for the patients for consideration of surgical*

Intervention for low back pain; but however conclusion of recent high quality studies on discography significantly questioned the use of a discography result as a preoperative indication for either discectomy or spinal fusion. At this time, the medical records did not document findings that would support a possible spinal fusion procedure and with ODG not recommending discography due to the current studies, the recommendation is non certification of the requested CT discogram of the lumbar spine."

On December 3, 2013, noted the patient continued to have constant lumbar pain. The patient reported that overall symptoms were increasing and he was finding it more difficult to function on his activities of daily living (ADL). On exam, the patient stood from a seated position in a slow guarded motion. The lumbar spine had guarded movement that exacerbated on flexion, extension and rotation. He had decreased sensation on the right lateral thigh and bilateral lateral lower legs and hyperesthesia along the left lateral lower leg. There was a positive right SLR test and a positive right Patrick's. He had considerable muscular atrophy of the right leg. Because the patient's symptoms were constant, he felt they had become debilitating to him. Use of medications was not as effective as it had been in the past and the patient found it harder to functional on a day-to-day basis. encouraged the patient to be active but avoiding heavy lifting. An IRO was requested.

On January 3, 2014, it was noted that the patient's lumbar pain had remained constant and at times very aggressive. He found it difficult to function on a day-to-day basis due to lumbar pain and bilateral lower extremity radicular symptoms. On exam, the patient stood from a seated position slowly and guarded with pain on ROM throughout. He had decreased sensation on the right lateral thigh and bilateral lateral lower legs and hyperesthesia along the left lateral lower leg. There was a positive right SLR test and a positive right Patrick's. The atrophy of the left leg continued as before. The lumbar discogram was exclusively to evaluate whether or not the patient had discogenic symptoms. There had been no reply from the insurance company IRO. The patient was to continue to maintain proper body mechanics, avoid heavy lifting and stretch regularly. This report is signed.

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

There were extensive records for review dating back to the 1990 timeframe. The claimant at that time had been involved in a motor vehicle accident with subsequent neck, back and right hand pain. The patient was placed at maximum medical improvement with an impairment of 12%.

The next records are after the work incident which occurred on xx/xx/xx, when he was lifting and felt pain into his back.

The patient had treatment documented throughout xxxx with neurosurgeon. The patient subsequently underwent surgical intervention to include a transforaminal

interbody fusion at L5-S1 on January 12, 2000. The patient however did not get good relief with the procedure and underwent subsequent assessment for possible spinal cord stimulator placement. On November 22, 2005, performed a permanent spinal cord stimulator implantation. documented throughout 2007, that the patient was stable with the spinal cord stimulator. However, on September 24, 2007, noted that the patient was having 75% of his discomfort into his left lower extremity. diagnosed lumbar radiculopathy and lumbar spondylosis.

In 2008, noted the patient was increasing his utilization of hydrocodone. The patient appeared to have a solid fusion and possibly a spontaneous fusion at L3-L4, however, a CT scan did not validate the L3-L4 level to be fused.

The patient continues to follow up. On January 20, 2009, the spinal cord stimulator was removed.

The patient in April 2009 also had hardware injection of the L5-S1 level.

became involved in the claimant's care in 2010. He proposed longer acting narcotics such as OxyContin. The patient was also utilizing Dilaudid. The patient then had subsequent evaluation for symptomatic hardware. The lumbar discogram was proposed on September 29, 2010. The patient had a lumbar MRI on October 15, 2010, showing L3-L4 facet arthrosis and ligamentum flavum hypertrophy but without significant canal or foraminal stenosis. At the L4-L5 level, there was facet arthrosis and osteophytic ridging with mild stenosis. L5-S1 was solidly fused.

again recommended a discogram in October 2010. The patient also had facet blocks performed in February 2011, at L4-L5 and L5-S1. reported that the patient had 100% relief of the lumbar pain for up to ten days after the facet injections.

The records document the care including a medication prescriptions.. The patient had another MRI of the lumbar spine on September 4, 2013. This noted that the hardware had been removed at L5-S1 level. There was disc desiccation at the L3-L4 and L4-L5 levels. There were facet changes at both levels. There was no significant foraminal stenosis reported but there was mild central narrowing at the L4-L5 level, per the radiologist report. again proposed a lumbar discogram. Utilization review was completed noting the patient had had the previous fusion with then subsequent spinal cord stimulator placement and removal, hardware removal and now proposal for discography and further fusion surgery potentially.

The utilization review did not validate that there was a medical necessity for the CT discogram based on clinical documentation as well as coordination with the ODG.

Summary: This is a gentleman with a long term back disorder with multiple treatment regimens being provided over the years without significant benefit obviously documented on a longer term basis. The patient has had facet injections which allegedly gave him very significant benefit even though the facet

injections were done at the L5-S1 level and L4-L5 yet the L5-S1 level was already fused. There was no documentation of spine instability or spine fracture. The patient does have very significant anterior osteophytosis already noted at L3-L4. There is no significant neurogenic disorder noted. The rationale for doing discography in this patient is not consistent with evidence based medicine. The likelihood of any significant benefit with this patient's pain control with the proposed procedure leading to any type of fusion procedure is not supported by the evidence based medicine. Thus the discogram as proposed at L2-L3, L3-L4 and L4-L5 is not approved. There is also literature that has suggested that the discography itself can be injurious to the disc.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
Reference
ODG-DWC low back