IRO NOTICE OF DECISION – WC

Claims Eval

Notice of Independent Review Decision

September 10, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LUMBAR CT/DISCOGRAM @ L4-S1 68890 72295 77003 99499 00630

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

American Board of Orthopaedic Surgery

REVIEW OUTCOME:

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

11-6-13, the claimant complains of back pain. Over time it has been worsening. Pain is located in the right lower back and is described as aching, sharp, and

shooting. The pain radiates to the right buttocks. It is associated with stiffness and swelling. Diagnosis: Lumbago. Plan: The claimant was prescribed Flexeril and Naprosyn.

11-11-13, the claimant complains of back pain. Over time it has been worsening. Pain is located in the right lower back and is described as aching, burning, sharp, and shooting. The pain radiates to the right buttocks. Diagnosis: Lumbago consider facet inflammation. Plan: The claimant was prescribed a Medrol Dosepak. The evaluator recommended physical therapy.

Physical Therapy on 11-12-13 through 1-13-14 (16 visits).

11-18-13, the claimant complains of back pain. Over time it has been unchanged. Pain is located in the right lower back and is described as aching, burning, sharp, shooting, and soreness. The pain radiates to the right buttocks and is associated with pain, stiffness, swelling, and burning sensation. Diagnosis: Lumbago. Plan: The claimant will continue current drug regimen. The claimant will continue physical therapy. The evaluator recommended a MRI of the lumbar spine.

11-20-13 MRI of the Lumbar Spine without contrast showed mild to moderate disc degenerative changes from L4-S1, modic type 1 degenerative endplate signal changes are seen on the right at L5-S1, central annular tear and disc protrusion at L4-5 without significant central canal stenosis or foraminal encroachment, mild to moderate right foraminal encroachment at L5-S1 is seen.

11-25-13, the claimant complains of back pain. Over time it has been improving. Pain is located in the right lower back and is described as aching and soreness. The pain radiates to the right buttocks and is associated with stiffness and burning sensation. Diagnosis: Lumbago. Plan: The claimant was prescribed Flexeril. The claimant will continue physical therapy.

12-2-13, the claimant complains of back pain. Over time it has been improving. Pain is located in the right lower back and is described as aching and soreness. The pain radiates to the right buttocks and is associated with stiffness and burning sensation. Diagnosis: Lumbago. Plan: The claimant will continue physical therapy and current drug regimen.

12-16-13, the claimant complains of back pain. Over time it has been improving. Pain is located in the right lower back and is described as aching and soreness. The pain radiates to the right buttocks and is associated with stiffness. Diagnosis: Cervical disc displacement without myelopathy, lumbago. Plan: The claimant was prescribed Flexeril. The claimant will continue physical therapy.

1-6-14, the claimant complains of back pain. The pain is located in the right lower back. The pain is described as soreness and radiates to the right buttock. The pain

is associated with stiffness. Diagnosis: Cervical disc displacement without myelopathy, lumbago. Plan: The claimant will continue current drug regimen.

1-20-14, the claimant complains of back pain that has been going on for 3-6 months. The claimant reported she bounced out her seat landing hard back into seat. Assessment: Lumbar spondylosis with facet syndrome L4-5 L5-S1, annular tear with disc protrusion at L4-5. Plan: The claimant was prescribed Naproxen, Cyclobenzaprine, Acetaminophen, Robaxin, and Ultracet. The evaluator recommended an x-ray of the lumbar spine.

2-6-14, the claimant complains of back pain. The claimant states climbing stairs makes it worse. The claimant states she is still sore and stiff. Diagnosis: Disc displacement not otherwise specified without myelopathy. Plan: The claimant is waiting for injections to be approved.

3-20-14, the claimant returned for a follow up. Her medial branch block was denied. The claimant continues to have some symptoms with low back pain and pain on extension. The claimant needs a refill of medications. Assessment: Lumbar spondylosis with facet syndrome L4-5 L5-S1, annular tear with disc protrusion at L4-5. Plan: The claimant was prescribed Celebrex, Robaxin, and Tramadol.

4-16-14, the claimant complains of significant low back pain. Assessment: Lumbar spondylosis with facet syndrome L4-5 L5-S1, annular tear with disc protrusion at L4-5. Plan: The claimant was prescribed Norco. The evaluator recommended a medial branch block at L4-S1, bilateral.

4-28-14, performed a Designated Doctor Evaluation. He certified that the claimant had reached MMI on 3-27-14 and awarded the claimant 5% whole person impairment.

5-28-14, the claimant complains of low back pain. Her medial branch blocks were denied again. Assessment: Lumbar spondylosis with facet syndrome L4-5, L5-S1, annular tear with disc protrusion at L4-5. Plan: The evaluator recommended a medical branch block.

7-17-14, the claimant complains of severe back pain. The claimant completed her medial branch blocks at L4-5 and L5-S1. She states this did not offer any relief. Assessment: Lumbar spondylosis with facet syndrome L4-5 L5-S1, annular tear with disc protrusion at L4-5. Plan: The evaluator recommended a CT discogram. The claimant was prescribed Medrol Dosepak and Norco.

7-31-14 UR. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The mechanism of injury was from the patient hitting a pothole while driving. Medications include Medrol, Norco, naproxen, cyclobenzaprine, acetaminophen, Robaxin, Ultram, tramadol, and

Celebrex. Surgical history was not provided in the medical records. Diagnostic studies include a lumbar MRI that revealed disc dislocation at L4-5 and L5-S1 with an annular tear at L4-5. Other therapies include medial branch blocks and physical therapy. The 07/17/2014 clinical note reported a complaint of low back pain rated 8/10. On examination, the patient had tenderness to the paraspinal region at the site of the facet joints in the lower lumbar spine and pain with extension. It was noted she did not have any relief from her medial branch blocks at L4-5 and L5-S1. The patient felt it exacerbated her low back pain. The note stated the patient continued to have severe, debilitating low back pain despite conservative treatments including physical therapy, medications, and medial branch blocks and indicated her pain may be discogenic in nature. As such, she was recommended a discogram for diagnostic and possible surgical planning. The Official Disability Guidelines state discography is not recommended; however, the criteria if the provider and payor agree to perform the procedure includes satisfactory results from a detailed psychological assessment in patients who meet surgical criteria for fusion. The documentation submitted did not provide evidence of a psychological assessment and did not provide evidence to support the need for a fusion.

8-12-14 UR. The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The mechanism of injury was from the patient operating a bus and hitting a dip in the road. Medications included Medrol Pak, Norco, naproxen, cyclobenzaprine, acetaminophen, Robaxin, Ultracet, tramadol and Celebrex. Surgical history was not provided in the medical records. Diagnostic studies include x-rays that were unremarkable and a lumbar MRI performed on 11/20/2013 that revealed mild to moderate disc degenerative changes from L4-5, Modic type I degenerative signal changes at the right L5-S1, central annular tear and disc protrusion at L5-S I without significant central canal stenosis or foraminal encroachment, and evidence of mild to moderate right foraminal encroachment at L5-51. Other therapies include physical therapy and a medial branch block. The 05/29/2014 office visit reported a complaint of ongoing low back pain. On examination, the patient had significant pain with extension, decreased range of motion in extension by 25 percent, and significant tenderness of the paraspinal region at the site of the facets joints. The 07/17/2014 office visit reported a complaint of low back pain rated 8/10. The note stated that the patient did not have any relief from her medial branch blocks at L4-5 and L5-S1. The patient felt that her pain was exacerbated by the injections. The examination did not indicate any changes upon physical examination. The note stated that her most recent MRI showed disc dislocation at L4-5 and L5-S1 with annular tears at L4-5 and indicated that conservative treatment measures including physical therapy, medications, and medial branch blocks have not eliminated her back pain. The note stated a CT discogram was necessary for diagnostic and possible surgical planning. The Official Disability Guidelines state discography is not recommended; however, the criteria if the provider and payor agree to perform the procedure include satisfactory results from a detailed psychological assessment and evidence the patient meets surgical criteria for fusion. The request was previously non-certified, as there was no

evidence of psychological assessment, and the documentation did not support the need for a fusion.

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

Medical records reflect a claimant with low back pain from a work related incident on xx/xx/xx. The claimant reports severe low back pain. The claimant has been treated with medications and medial branch block. On 11-20-13, MRI of the lumbar spine without contrast showed mild to moderate disc degenerative changes from L4-S1, modic type 1 degenerative endplate signal changes are seen on the right at L5-S1, central annular tear and disc protrusion at L4-5 without significant central canal stenosis or foraminal encroachment, mild to moderate right foraminal encroachment at L5-S1 is seen. She has been placed at MMI by a Designated Doctor and given a 5% impairment rating. There is a request for lumbar discogram. Current treatment guidelines reflect that discography is 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. This claimant has degenerative changes in the lumbar spine, for which IDET or a fusion would not be indicated. Therefore, the request for LUMBAR CT/DISCOGRAM @ L4-S1 68890 72295 77003 99499 00630 is not reasonable or medically necessary.

ODG 2014 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

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). (Carragee-*Spine*, 2000) (Carragee2-*Spine*, 2000) (Carragee3-*Spine*, 2000) (Carragee4-*Spine*, 2000) (Bigos, 1999) (ACR, 2000) (Resnick, 2002) (Madan, 2002) (Carragee-*Spine*, 2004) (Carragee2, 2004) (Maghout-Juratli, 2006) (Pneumaticos, 2006) (Airaksinen, 2006) (Manchikanti, 2009) Discography may help distinguish asymptomatic discs among morphologically abnormal discs in patients without psychosocial issues. Precise prospective categorization of discographic diagnoses may predict outcomes from treatment, surgical or otherwise. (Derby, 2005) (Derby2, 2005) (Derby, 1999) Positive discography was not highly predictive in identifying outcomes from spinal fusion. A recent study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. (Carragee, 2006) The prevalence of positive discogram may be increased in subjects with chronic low back pain who have had prior surgery at the level tested for lumbar disc herniation. (Heggeness, 1997) Invasive diagnostics such as provocative discography have not been proven to be accurate for diagnosing various spinal conditions, and their ability to effectively guide therapeutic choices and improve ultimate patient outcomes is uncertain. (Chou, 2008) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. (Cohen, 2005) Provocative discography is not recommended because its diagnostic accuracy remains uncertain, false-positives can occur in persons without low back pain, and its use has not been shown to improve clinical outcomes. (Chou2, 2009) This recent RCT concluded that, compared with discography, injection of a small amount of bupivacaine into the painful disc was a better tool for the diagnosis of discogenic LBP. (Ohtori, 2009) Discography may cause disc degeneration. Even modern discography techniques using small gauge needle and limited pressurization resulted in accelerated disc degeneration (35% in the discography group compared to 14% in the control group), disc herniation, loss of disc height and signal and the development of reactive endplate changes compared to match-controls. These finding are of concern for several reasons. Discography as a diagnostic test is controversial and in view of these findings the utility of this test should be reviewed. Furthermore, discography in current practice will often include injecting discs with a low probability of being symptomatic in an effort to validate other disc injections, a so-called control disc. Although this strategy has never been confirmed to increase test validity or utility, injecting

normal discs even with small gauge needles appears to increase the rate of degeneration in these discs over time. The phenomenon of accelerated adjacent segment degeneration adjacent to fusion levels may be, in part, explained by previous disc puncture if discography was used in segments adjacent to the fusion. Similarly, intradiscal therapeutic strategies (injecting steroids, sclerosing agents, growth factors, etc.) have been proposed as a method to treat, arrest or prevent symptomatic disc disease. This study suggests that the injection procedure itself is not completely innocuous and a recalculation of these demonstrated risks versus hypothetical benefits should be considered. (Carragee, 2009) More in vitro evidence that discography may cause disc degeneration. (Gruber, 2012) Discography involves the injection of a water-soluble imaging material directly into the nucleus pulposus of the disc. Information is then recorded about the pressure in the disc at the initiation and completion of injection, about the amount of dye accepted, about the configuration and distribution of the dye in the disc, about the quality and intensity of the patient's pain experience and about the pressure at which that pain experience is produced. Both routine x-ray imaging during the injection and post-injection CT examination of the injected discs are usually performed as part of the study. There are two diagnostic objectives: (1) to evaluate radiographically the extent of disc damage on discogram and (2) to characterize the pain response (if any) on disc injection to see if it compares with the typical pain symptoms the patient has been experiencing. Criteria exist to grade the degree of disc degeneration from none (normal disc) to severe. A symptomatic degenerative disc is considered one that disperses injected contrast in an abnormal, degenerative pattern, extending to the outer margins of the annulus and at the same time reproduces the patient’s lower back complaints (concordance) at a low injection pressure. Discography is not a sensitive test for radiculopathy and has no role in its confirmation. It is, rather, a confirmatory test in the workup of axial back pain and its validity is intimately tied to its indications and performance. As stated, it is the end of a diagnostic workup in a patient who has failed all reasonable conservative care and remains highly symptomatic. Its validity is enhanced (and only achieves potential meaningfulness) in the context of an MRI showing both dark discs and bright, normal discs -- both of which need testing as an internal validity measure. And the discogram needs to be performed according to contemporary diagnostic criteria -- namely, a positive response should be low pressure, concordant at equal to or greater than a VAS of 7/10 and demonstrate degenerative changes (dark disc) on MRI and the discogram with negative findings of at least one normal disc on MRI and discogram. See also Functional anesthetic discography (FAD).

Discography is Not Recommended in ODG.

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)**