

# Medical Assessments, Inc.

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## **IRO CASE #:**

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

Lumbar Discogram with CT T7-8, T8-9 to Include CPT Codes 62291 X 2, 72129, 72295-26

### **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 13 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.

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

The claimant is a male who was injured on xx/xx/xx in a fall off a ladder. The claimant was diagnosed with acute compression fracture of T8.

06/25/2014: Office Visit. **HPI:** Claimant was seen after having a selective nerve root block at T7-8 to the right on 5/28/14. Claimant reported he did get some improvement after the injection. Pain went from 8/10 down to 2-7/10 depending on the day. **Medications:** Advair , Norco 10-325mg, Cyclobenzaprine 10mg, Advil, Gralise Starter 300&600, Gralise 600mg, Gabapentin 300mg.

07/16/2014: Office Visit. Claimant reported his pain radiates to the right side and under the right arm around to the front. He stated the pain has gotten better after the injection. He manages his pain with Hydrocodone 10 3 times a day as well as Neurontin 600mg and Flexeril 3 times a day. **Plan:** Ordered MRI.

07/29/2014: MRI of T-Spine W/O Contrast. **Impression:** Schmorl Node deformities within the superior endplates of T3 and T8 vertebrae. Otherwise unremarkable MRI of the thoracic spine.

08/13/2014: Office Visit. **MRI review:** Claimant's new MRI does show that the 7-8 disk remains the worse. He has had an interval fracture or injury to the T3 vertebral body.

11/19/2014: Office Visit. Claimant reported that he tried the Tylenol with codeine; however it did not help with his pain. Refilled Hydrocodone.

01/21/2015: Office Visit. Claimant was seen for a follow up. **Plan:** Ordered a diskogram CT at the T7-8 and T8-9 level and see him back to review the results. In regard to managing his pain, continued him on medication and have recommended repeating the injection. The last injection did not work, but the second to the last injection was effective, relieving about 50% on his pain for about a month.

02/11/2015: Office Visit. Claimant was seen for medication follow up. **New medication:** Trazodone hcl tabs.

03/30/2015: Behavioral Health Psych Evaluation. Based on the clinical health psychology evaluation, the claimant is clear to proceed to discography, without any concern that psychosocial factors will impact the results. The claimant works full time, limited duty. He can only do about 20%-25% of what he did at work prior to the injury.

04/15/2015: Office Visit. Claimant was seen with thoracic pain as well as right-sided rib pain. He states the pain has increased over the last several days. Pain rates 6-7/10. He is managing his pain with Hydrocodone, Flexeril and Neurontin.

04/09/2015: UR. Rationale for denial: The claimant is a male who was injured on xx/xx/xx, in a fall off of a ladder. The claimant was diagnosed with an acute compression injury of the T8 vertebra. An MRI of the lumbar spine on February 7, 2007, suggested the acute fracture deformity of the anterior two-thirds of the T8 vertebral body, with mild compression of the superior endplate of the T8 vertebral body of less than 20-30%. The request cannot be supported based on the documentation provided. The claimant has chronic reports of low back pain. The claimant was denied prior surgery due to lack of objective documentation of diagnostic imaging confirming pathology at the requested levels. The 2015 progress notes report subjective pain and stable gait, with a lack of substantial clinical findings. The request for lumbar discogram with CT at T7-8 and T8-9 is not certified.

04/23/2015: UR. Rationale for denial: The claimant is a male who was injured on xx/xx/xx, in a fall off a ladder. The claimant was diagnosed with acute compression fracture of T8 vertebral body with mild compression of the superior endplate of T8 of less than 20-30%. There is lack of substantial documentation

supporting the medical necessity for further diagnostic testing at this time, such as discography. Without full objective documentation of deficits on examination and/or MRI documenting pathology, the request is not supported. The claimant is working full-time limited duty at the time. The reconsideration request for lumbar discogram with CT at T7-8, T8-9 is not certified.

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

The request for discography with CT scan at T7-8 and T8-9 is denied.

The thoracic spine MRI of 7/29/2014 demonstrated Schmorl's Nodes in the superior endplates of T3 and T8. No other abnormalities were noted in this study. Specifically, there were no significant disc bulges or herniations associated with central or foraminal stenosis. The marrow signal and vertebral alignment were normal throughout the thoracic spine. This study did not indicate any discogenic abnormalities that could be associated with the patient's current pain complaints.

Furthermore, the Official Disability Guidelines (ODG) do not support discography. The literature indicates that discography has limited diagnostic value. Discography may be considered prior to fusions in the lumbar spine, not in the thoracic spine.

The patient does not require a thoracic discogram with CT scan.

Therefore, the request for Lumbar Discogram with CT T7-8, T8-9 to Include CPT Codes 62291 X 2, 72129, 72295-26 is non-certified.

### **ODG Guidelines:**

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 findings 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.**

**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)**