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Notice of Independent Review Decision

Case Number:

Date of Notice: 01/21/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Lumbar Discogram L3-4, L4-5, L5-S1

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)

Patient Clinical History (Summary)

The patient is a male with a history of low back pain dating to XX/XX/XX injury in which the claimant was lifting a heavy object.

An MRI of the lumbar spine performed on XX/XX/XX was noted to reveal no evidence of disc herniation, thecal sac stenosis, or neural foraminal encroachment at L1-2 and L2-3; broad 1 mm disc bulge at L3-4; no evidence of disc herniation, thecal sac stenosis, or neural foraminal encroachment at L4-5; broad 1 mm disc protrusion/herniation at 1.5 mm left posterolateral component with associated mild left neural foraminal narrowing as well as a left posterolateral zone of hyperintensity at T2 suggesting the disc protrusion is secured or acutely irritated at L5-S1; small facet joint effusions are seen at L3-4 and L4-5 indicative of acute facet joint irritation on lumbar facet syndrome.

An electrodiagnostic study dated XX/XX/XX indicated there was no electrodiagnostic evidence of left lumbosacral radiculopathy at L3 through S1.

A psychological evaluation dated XX/XX/XX indicated the patient was clear from a psychological standpoint for lumbar discogram and if necessary spinal surgery.

An MRI of the lumbar spine completed XX/XX/XX was noted to reveal 2 to 3 mm posterior central protrusion/herniation with associated 3 to 4 mm of inferior substance extrusion at L5-S1.

A clinical note dated on XX/XX/XX indicated the patient had complaints of low back and left buttock pain. The patient rated this pain a 3/10 to 9/10. It was noted at that time a physical therapy, chiropractic therapy, lumbar facet injection provided no significant benefit. The patient was noted to have been found to have avascular necrosis of the hips noted on MRI scan on XX/XX/XX. However, the patient saw an orthopedic surgeon who felt that the patient's symptomatology was coming from the low back and not the hips. On physical examination, the patient had tenderness to palpation on the left lumbar spine. Straight leg raise was

negative bilaterally. Motor exam demonstrated 5/10 strength in all lower extremity muscle groups. It was recommended at that time the patient undergo a lumbar discogram to see if they can confirm the pain generator as the patient's L5-S1 disc is suspected.
A History and Physical dated XX/XX/XX indicated that since the date of injury on XX/XX/XX, the patient had been having constant throbbing and achy low back pain that radiated to the left lower extremity that was rated 8/10 and associated with numbness, tingling, and weakness on the left leg. The patient denied any bowel or bladder dysfunction. The patient was also noted to have been receiving medication but continues to restricted. There was no evidence of babinski's or clonus bilaterally. Sensation was normal. Straight leg raise was positive on the left at 30 degrees. Muscle strength was 5/5 throughout except in ankle dorsiflexors and plantarflexors measured 4/5. It was recommended that the patient undergo a lumbar discogram with postoperative CT scans at the level of L3-4, L4-5 and L5-S1 in order to pinpoint the source of the patient's pain and consider a possibility and type of further intervention therapy if necessary.

A letter of Appeal dated XX/XX/XX indicated the patient continues to have significant low back pain and at least central bulge at L5-S1 that is associated with 3 to 4 mm inferior substance extrusion that is likely resulting as discogenic pain. The patient was noted to have failed conservative therapy and is a candidate for surgery. The letter also states that the patient has a microdiscectomy, the bulge in the disc will remain and that if this is not painful lumbar disc then his symptomology will continue and the patient will ultimately require fusion. Therefore, as they are suspecting discogenic pain at L5-S1, a lumbar discography is requested.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

According to the American Pain Society, provocative discography is not recommended as a procedure for diagnosing discogenic low back pain as the diagnostic accuracy for identifying discogenic pain remains uncertain. In addition, the American Pain Society also states that degenerative disc disease is common in asymptomatic persons and there remains no reliable reference standard for distinguishing symptomatic from asymptomatic imaging findings and even though positive pain responses with provocative discography are unlikely in healthy, asymptomatic patients without back pain, false-positive responses are common in persons without significant back pain. The American Pain continues by stating that there is no evidence that use of provocative discography to select patients for fusion leads to improved clinical outcomes. In addition, in an article titled "Does discography cause accelerated progression of degeneration changes in the lumbar disc: A ten-year cohort-controlled study" it found that discography procedures have been shown to result in accelerated disc degeneration, disc herniation, loss of disc height and signal and the development of reactive endplate changes compared to match-controls.

While provocative discography was once used for diagnosing discogenic low back pain, recent research has shown that the diagnostic accuracy for identifying discogenic pain remains unclear and there is no evidence that it provides better clinical outcomes. In addition, discography has been shown to result in significant side effects to include increased rates of disc degeneration, disc herniation, loss of disc height and the development of reactive endplate changes. Furthermore, the documentation provided induces evidence of radiculopathy as the patient has complaints of numbness and tingling down the left lower extremity as well as objective evidence of positive straight leg raise on the left and decreased strength in the ankle dorsiflexes and plantar flexors. Provocative discography is not recommended in patient with radiculopathy. Therefore, the request for a lumbar discogram at L3-4, L4-5, and L5-S1 is not medically necessary and thus the previous determination is upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual

☑ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)

Carragee, E. J., Don, A., Hurwitz, E., Cuellar, J., Carrino, J., & Herzog, R. (2009). Does discography cause accelerated progression of degeneration changes in the lumbar disc: A ten-year cohort-controlled study. Spine Journal Meeting Abstracts. LWW.

☑ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Chou, R., Loeser, J. D., Owens, D. K., Rosenquist, R. W., Atlas, S. J., Baisden, J., ... & Stanos, S. P. (2009). Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain: an evidence-based clinical practice guideline from the American Pain Society. Spine, 34(10), 1066-1077.