Medical Assessments, Inc.

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IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
CT Discogram Lumbar Spine L3-S1 62290 x 3, 72297 x 3,72131

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Orthopedic Surgeon with over 15 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 XX who sustained an injury on XX while XX.

XXXX: History and Physical by XX. The claimant reported 100% low back pain and reported pain level 8-10/10.

XXXX: CT Myelogram by XX: CT Myelogram done on XXXX showed a retrolisthesis at L5-S1 with spondylosis and mild to moderate foraminal narrowing. Mild to moderate canal narrowing at L4-5 and L5-S1. Degenerative disc disease was most prominent at L5-S1 with mild to moderate left and moderate right inferior foraminal narrowing by disc bulge and spondylotic changes.

XXXX: Office visit by XX. Claimant complains of continued low back pain. Pain rated as a 6/10 with right leg weakness. XX had weakness in XX right leg. Completed PT, PE reveals antalgic gait. Decreased motor strength bilateral dorsiflex and EIL 4+/5 on right and 5-/5 on left. The lumbar spine had unremarkable findings. XX medications were XX 300 mg, XX 10-325mg, XX 350mg, XX 25mg, XX #3, XX 300mg and XX 20mg.

XXXX: UR performed by XX. Rationale for denial: The claimant is a XX who sustained an injury on XXXX while on XX. The patient complained of low back pain with a pain score of 6/10. However, the objective findings were unremarkable. There was no clear documentation of failure from conservative treatments including active PT. Moreover, there was no detailed psychosocial assessment submitted to note satisfactory results. Thus, the request is not substantiated.

XXXX: UR performed by XX. Rationale for denial: The patient has recommended computed tomography discogram of the lumbar spine. However, there was limited documentation if the patient had failed all conservative treatment since there were not actual PT reports submitted. In addition, the guidelines

recommended single level testing with control. There were no extenuating factors identified to support the need for discography at this time. Thus, the request is not supported.

XXXX: Follow up note by XX. Claimant reported not seeing any improvement. XX still has significant pain in XX low back that is fairly localized. XX has no radiating symptoms. No sensory deficits or paresthesias.

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

The request for CT discogram is denied.

This patient sustained a lumbar injury in XXXX. XX currently has lower back pain, without any radicular complaints. XX has mild weakness in the right foot. XX has completed the following studies:

The lumbar MRI (XXXX) reported disc space narrowing at L5-S1.

1. Electrodiagnostic testing (XXXX) identified right S1 radiculopathy.
2. Flexion-extension plainfilms of the lumbar spine (XXXX) determined 4 mm of translation at L5-S1 with disc space narrowing at this level.
3. The CT mylogram (XXXX) demonstrated L5-S1 degenerative disc disease with grade I retrolisthesis and moderate right foraminal narrowing. Grade I retrolisthesis at L2-3 was also noted, without nerve impingement on the exiting L2 nerves.

The Official Disability Guidelines (ODG) does not support discography. However, it can be used as a screening tool for surgical decision-making, specifically in cases where a lumbar spinal fusion is being considered.

According to the records reviewed, the primary pain generator is the L5-S1 level. Furthermore, there is no definite plan for surgical intervention in this patient.

The requested study is not medically necessary.

Discography is Not Recommended in ODG.
However, if provider and payer agree to perform anyway, the following patient criteria are recommended:
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)**