

<b>Case Number:</b>	CM13-0068177		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	08/19/2006
<b>Decision Date:</b>	04/11/2014	<b>UR Denial Date:</b>	12/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a female with date of injury of 8/19/2009. According to the progress report by the primary treating physician, the injured worker is experiencing moderate to severe low back pain, which radiates down her left lower extremity. She has pain as high as 9-10/10, and with medication use it is reduced to 4-5/10. On exam she shows range of motion deficits to her low back, at 70% of normal. There is pain to palpation from L4 to S1, left and right paraspinal musculature, left worse than right. There is allodynia and decreased sensitivity to the posterior aspect of her left lower extremity extending from her buttocks all the way down to her heel. There is a positive straight leg raise at 40 degrees on the left and negative on the right. There is weakness with extensor hallucis longus (EHL) function, 3/5 on the right and 4/5 on the left. The diagnosis is degenerative disc disease of the lumbosacral spine with L4-5 and L5-S1 bilateral radiculopathy, left worse than right. The treatment plan includes medications and lumbar discogram.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**NEEDLE LOCALIZATION BY X-RAY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Low back, Discography

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 303-305.

**Decision rationale:** Per the ACOEM Guidelines, the use of lumbar discogram is not useful in identifying the symptomatic high-intensity zone, and concordance of symptoms with the disk injected is of limited diagnostic value. This is noted to be especially inaccurate if chronic or with abnormal psychological tests, both of which there is documented record of for this injured worker. The discogram can produce significant symptoms in controls more than a year later. Discograms are supported by these guidelines when a fusion is a realistic consideration, and it is expected that the discogram may provide supplemental information prior to surgery. The request for this procedure is not accompanied by any discussion of plans for spinal fusion, however. Per psychiatric evaluation in May 2013, the injured worker has Axis I diagnoses of 1) depressive disorder NOS 2) Pain disorder associated with both psychological factors and a general medical condition 3) Opiate dependence. The ACOEM Guidelines caution against the use of discogram, particularly in subjects with emotional and chronic pain problems because this profile has been linked to reports of significant back pain for prolonged periods after injection. The request for needle localization by x-ray is determined to not be medically necessary.