

<b>Case Number:</b>	CM14-0026226		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	01/04/2011
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 54-year-old female who reported an injury on 01/04/2011 due to an unknown mechanism. Diagnoses were status post anterior cervical fusion and discectomy C5-6 and C6-7 with probable cervical spondylosis at C4-5, painful mass distal right wrist, etiology undetermined. Multilevel degenerative disc disease lumbosacral spine with radiculopathy and axial back pain, probably facet generated. Internal derangement, rule out foreign medial meniscus right knee, and the removal of pulse generator unit in dorsal column stimulator on 05/14/2013. Past treatments have consisted of lumbar epidural steroid injections, trigger point injections, and spinal cord stimulator. Diagnostic studies were MRI and CAT scan of the lumbar spine, and an EMG/nerve conduction study. The EMG revealed evidence of worsening of the study since 01/24/2012, bilateral L5 radiculopathy and mild bilateral S1 radiculopathy as well as ongoing denervation due to the left S1 radiculopathy. MRI of the lumbar spine on 07/16/2013 revealed a 3.7 mm circumferential disc bulges with moderate disc desiccation and moderate neural foraminal narrowing with a posterior annular tear noted at L3-4 and L5, and, to a less extent, L5-S1. The L2-3 level does reveal a 2.8 mm circumferential disc bulges with facet arthrosis. Lumbar spine CT myelogram performed 07/03/2012 revealed a 3 mm to 4 mm disc protrusion at L2-3, L3-4, and L4-5 with bilateral neural foraminal stenosis. Physical examination on 01/14/2014 revealed complaints of cervical and lumbar pain. There was complaint of mild to moderate neck pain that continued to be the most problematic. There were complaints of bilateral upper extremity radiculopathy. There were complaints of severe low back pain, the pain was measured a 10/10. The injured worker was experiencing fecal incontinence. She also continued to experience paresthesias and numbness of the perineum and vaginal region. Examination of the cervical spine revealed there was normal sagittal balance of the cervical spine. There was no abnormal lordosis, kyphosis, or scoliosis. There was slight

spinous process tenderness. There was slight paraspinal muscle guarding with minimal tenderness. There was negative occipital tenderness. There was slight trapezius spasm without significant tenderness. Range of motion for flexion was to 40 degrees, extension was to 30 degrees, left side bending was to 20 degrees, right side bending was to 20 degrees. There were no sensory or motor deficits for either upper extremity. Examination of the lumbosacral spine revealed there was tenderness of the mid to lower lumbosacral spine from L3 to the sacrum. There was moderate to severe paraspinal muscle guarding and tenderness. There was moderate guarding of movement. There was negative left sciatic notch tenderness. There was negative right sciatic notch tenderness. Range of motion for flexion was to 35 degrees, extension was to 0 degrees with increased pain, left side bending was to 10 degrees, right side bending was to 10 degrees. Sensory examination revealed there was hypesthesia of the lateral dorsum of both feet. There was slight mid dorsal hypesthesia and lateral hypesthesia of the feet. Motor strength revealed weakness of the right great toe extensor and the right anterior tibialis. There was also weakness of the left great toe extensor and left anterior tibialis as well as left quadriceps. Straight leg raising test for the left leg was to 70 degrees, the right leg was to 70 degrees. Medications were not reported. Treatment plan was for decision of an outpatient lumbar discogram for the L2-3, L3-4, L4-5 and L5-S1. The rationale and Request for Authorization were not submitted.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**OUTPATIENT LUMBAR DISCOGRAM L2-3, L3-4, L4-5, L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** The California ACOEM states recent studies on discography do not use it as a preoperative indication for either intradiscal electrothermal annuloplasty or fusion. Discography does not identify the symptomatic high intensity zone, and concordance of symptoms with the disc injected is of limited diagnostic value (common in non back issue patients, and accurate if chronic or abnormal psychosocial tests), and it can produce significant symptoms in controls more than a year later. Tears may not correlate anatomically or temporarily with symptoms. Discography may be used where fusion is a realistic consideration, and it may provide supplemental information prior to surgery. This area is rapidly evolving, and clinicians should consult the latest available studies. Despite the lack of strong medical evidence supporting it, discography is fairly common, and when considered common, it should be reserved only for patients who meet the following criteria (back pain of at least 3 months duration, failure of conservative treatment, satisfactorily 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.) The patient should be a candidate for surgery and has been briefed on potential risks and benefits from discography and surgery. The injured worker has not had any psychosocial

testing prior to the discography. Therefore, the request for Outpatient Lumbar Discogram L2-3, L3-4, L4-5, L5-S1 is not medically necessary.