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| Case Number: | CM14-0076072 | | |
| Date Assigned: | 07/16/2014 | Date of Injury: | 03/25/2011 |
| Decision Date: | 08/22/2014 | UR Denial Date: | 05/22/2014 |
| Priority: | Standard | Application Received: | 05/23/2014 |

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 Orthopedic Surgery, 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 patient is a 58 year old female who was injured on 03/25/2011 when she was carrying bags of planting mix. One bag started to fall and she went to catch it and felt low back pain. Prior medication history included Norco, Soma, and Celexa. The patient underwent L4-5 discectomy in 2006. Prior treatment history has included physical therapy, facet blocks, nerve burn treatments and all have not provided her with significant long-term relief or increased functioning. Orthopedic spine note dated 05/07/2014 states the patient presented with complaints of low back pain rated as a 6/10. She reported continued numbness in the left lower extremity to the top and bottom of foot. On exam, she has an antalgic gait favoring the right lower extremity. There is tenderness to palpation over the L5-S1 region. Her sensation is decreased over the left L4 and L5 dermatome distributions. Range of motion of the lumbar spine revealed flexion to 33 degrees with pain; extension to 20 degrees; left lateral bending to 25 degrees with pain and right lateral bending to 20 degrees. She is diagnosed with mild stenosis at L4-L5, depression, lumbar disc disorder with myelopathy, L4-5 grade 1 spondylolisthesis, L4-L5 facet arthropathy, and left leg radiculopathy. A discogram of the lumbar spine at L3-S1 was recommended as well as pain management. Prior utilization review dated 05/22/2014 states the request for Lumbar Discogram L3-S1 with negative control is denied as discogram outcomes have not been found to be consistently reliable for the low back and it is indicated as medically necessary nor reasonable at this time

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Discogram L3-S1 with negative control: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Discography.

Decision rationale: The guidelines do not support discography. According to the Official Disability Guidelines, if the provider and payor agree to perform the procedure anyway, patient selection criteria for Discography include only single level testing (with control). This request of L3-S1 discogram is not supportable. Regardless, as stated, discography is not recommended by the guidelines. Per the CA MTUS and ODG, recent studies on discography do not support its use as a preoperative indication. Discography does not identify the symptomatic high-intensity zone, and concordance of symptoms with the disk injected 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. The medical records do not provide a valid rationale for proceeding with a potentially painful test that has not been found to have any reliable clinically relevant diagnostic value.