

Case Number:	CM13-0064793		
Date Assigned:	01/03/2014	Date of Injury:	12/06/2006
Decision Date:	02/28/2015	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/12/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 63 year male with a date of injury of December 6, 2006. Results of the injury include neck and low back pain. Diagnosis include lumbar disc protrusion, lumbar degenerative disc disease, lumbar radiculopathy, and lumbar stenosis. Treatment has included medical imaging, home exercise program, chiropractic treatment, lumbar epidural steroid injections with relief, Norco, Anaprox, Fexmid, and prilosec. Magnetic Resonance Imaging (MRI) scan of the cervical spine dated May 15, 2013 revealed 2.5 mm disc protrusion of the nucleus pulposus/dehiscence at C6-7 and C5-6. At C4-5 and C3 there are 2 mm disc bulges with associated facet arthropathy. MRI scan of the lumbar spine dated May 15, 2013 revealed a 2 mm disc bulge at L5-S1 with associated facet arthropathy and bilateral neural foraminal stenosis. At L4-5 there is a 2.5 mm disc protrusion/dehiscences with associated facet arthropathy. EMG of the bilateral upper extremities dated January 11, 2013 revealed bilateral carpal tunnel syndrome, bilateral ulnar nerve entrapment at the elbow. Progress report dated November 12, 2013 showed there was tenderness, guarding, and spasm to the lumbar paravertebral region bilaterally. Range of motion was restricted due to pain and spasm. Treatment plan included a CT discogram of the lumbar spine and home exercise program. Utilization review form dated December 2, 2013 non certified CT discogram lumbar spine due to noncompliance with ACOEM treatment guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT DISCROGRAM LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Low back, Discogram

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, CT discogram lumbar spine is not medically necessary. The guidelines indicate imaging is not recommended. CT discogram is indicated when magnetic resonance imaging cannot be performed. The primary indication for provocative discography is to determine whether a patient with chronic spinal pain, who has failed aggressive efforts of conservative care, can be helped with spinal fusion. The ODG states discography is not recommended. Discography has been used in the past as part of the preoperative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high-quality studies on discography has significantly questioned the use of discography results as a preoperative indication for spinal fusion or IDET. The estimated predictive value appears to be at or below 50% which means the test is not helpful. These studies have failed to find discography reliably indicates what particular disc is the source of the patients pain. The ODG states discography is not recommended. Discography has been used in the past as part of the preoperative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusion of recent high-quality studies on discography has significantly questioned the use in this case. The injured workers working diagnoses are lumbar degenerative disc disease; lumbar radiculopathy; and lumbar stenosis. In July 2013 progress note indicates the injured worker received relief of radiculopathy symptoms with medications and epidural steroid injections. The documentation from a September 3, 2013 progress note shows the injured worker feels worse complaining of headache and neck pain, back pain shoulder and knee pain and abdominal pain. He complains of weakness and numbness in the lower extremities the swelling in the head. Lifting pushing pulling and twisting aggravates his symptoms. Physical examination is limited to the lumbar spine where there is tenderness palpation in the paravertebral region bilaterally with range of motion restriction to pain and spasm. There were no other physical findings in the medical record on September 3, 2013 progress note. In October 11, 2013 progress note indicates the injured worker received a series of two lumbar epidural steroid injections on June 20 of 2012 and September 6 of 2012 which provided close to three months of relief. The documentation does not contain evidence of repeat epidural steroid injections. The guidelines state discography is not helpful or recommended. Consequently, based on guideline recommendations whereby discography is not considered helpful or recommended based on the predictive value, e.g. discogram lumbar spine is not medically necessary.