

<b>Case Number:</b>	CM14-0203813		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	08/30/1995
<b>Decision Date:</b>	02/09/2015	<b>UR Denial Date:</b>	11/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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 Rehabilitation, has a subspecialty in Pain 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:

This is a 58 year old male with a work related injury dated 08/30/1995 with subsequent lumbar fusion. Mechanism of injury was not noted in received medical records or in Utilization Review report. According to a follow up note dated 10/07/2014, the injured worker presented with complaints of constant left > right neck pain to shoulders and deltoids with tingling in fingers and continued stabbing pain in low back and lower extremities with burning in feet. Diagnoses included chronic pain syndrome, lumbar postlaminectomy syndrome, lumbar radiculitis, lumbago, lumbar intervertebral disc degeneration, cervical spondylosis, and cervical radiculitis. Treatments have consisted of previous lumbar fusion, physical therapy, home exercises, Synvisc injections to bilateral knees, and medications. Diagnostic testing included MRI of the lumbar spine on 05/21/2012 revealed L1-L2, L2-L3, L3-L4 disk degeneration with bilateral neural foraminal stenosis at L3-4 and foraminal stenosis at L2-L3. Electromyography and nerve conduction studies showed chronic bilateral L4 radiculopathy and peripheral polyneuropathy affecting the sensory nerves more than motor. Work status is noted as unable to return to work. On 11/25/2014, Utilization Review denied the request for Lumbar Discogram L1-2, L2-3, L3-4, MRI Lumbar Spine, and Ambien 5mg citing Medical Treatment Utilization Schedule American College of Occupational and Environmental Medicine and Official Disability Guidelines. The Utilization Review physician stated there was insufficient documentation of medical necessity consistent with California Medical Treatment Utilization Schedule and evidence based treatment guidelines regarding the Lumbar Discogram. In regards to the MRI Lumbar Spine, there is no documentation of re-injury or acute exacerbation since MRI scan of the lumbar spine in 2012. In regards to the Ambien, the primary treating physician had not addressed the issue of sleep hygiene, goals to be achieved, or the duration on the use of this medication. In addition, the case is chronic and long term use of a hypnotic is not recommended

as first line treatment. Therefore, the Utilization Review decision was appealed for an Independent Medical Review.

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

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

#### **Lumbar Discogram L1-2, L2-3, L3-4: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

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

**Decision rationale:** ACOEM, Occupational Medicine Practice Guidelines; low back chapter, page 305 states: "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, it should be reserved only for patients who meet the following criteria: - Back pain of at least three months duration.- Failure of conservative treatment.- 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.)- Is a candidate for surgery?- Has been briefed on potential risks and benefits from discography and surgery."The Official Disability Guidelines (ODG) low back chapter, discography heading state the following: "Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) 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.) Also, the findings of discography have not been shown to consistently correlate well with the finding of a High Intensity Zone (HIZ) on MRI. Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not allow fusion). Discography may help distinguish asymptomatic discs among morphologically abnormal discs in patients without psychosocial issues. Precise prospective categorization of discographic diagnoses may predict outcomes from treatment, surgical or otherwise. (Derby, 2005) (Derby2, 2005) (Derby, 1999) Positive discography was not highly predictive in identifying outcomes from spinal fusion. A recent study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients

having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. (Carragee, 2006) The prevalence of positive discogram may be increased in subjects with chronic low back pain who have had prior surgery at the level tested for lumbar disc herniation. (Heggeness, 1997) Invasive diagnostics such as provocative discography have not been proven to be accurate for diagnosing various spinal conditions, and their ability to effectively guide therapeutic choices and improve ultimate patient outcomes is uncertain. (Chou, 2008) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. (Cohen, 2005) Provocative discography is not recommended because its diagnostic accuracy remains uncertain, false-positives can occur in persons without low back pain, and its use has not been shown to improve clinical outcomes. (Chou2, 2009) This recent RCT concluded that, compared with discography, injection of a small amount of bupivacaine into the painful disc was a better tool for the diagnosis of discogenic LBP. (Ohtori, 2009) Discography may cause disc degeneration. Even modern discography techniques using small gauge needle and limited pressurization resulted in accelerated disc degeneration (35% in the discography group compared to 14% in the control group), disc herniation, loss of disc height and signal and the development of reactive endplate changes compared to match-controls. These findings are of concern for several reasons. Discography as a diagnostic test is controversial and in view of these findings the utility of this test should be reviewed. Furthermore, discography in current practice will often include injecting discs with a low probability of being symptomatic in an effort to validate other disc injections, a so-called control disc. Although this strategy has never been confirmed to increase test validity or utility, injecting normal discs even with small gauge needles appears to increase the rate of degeneration in these discs over time. The phenomenon of accelerated adjacent segment degeneration adjacent to fusion levels may be, in part, explained by previous disc puncture if discography was used in segments adjacent to the fusion. Similarly, intradiscal therapeutic strategies (injecting steroids, sclerosing agents, growth factors, etc.) have been proposed as a method to treat or prevent symptomatic disc disease. This study suggests that the injection procedure itself is not completely innocuous and a recalculation of these demonstrated risks versus hypothetical benefits should be considered. (Carragee, 2009) More in vitro evidence that discography may cause disc degeneration. (Gruber, 2012) Discography involves the injection of a water-soluble imaging material directly into the nucleus pulposus of the disc. Information is then recorded about the pressure in the disc at the initiation and completion of injection, about the amount of dye accepted, about the configuration and distribution of the dye in the disc, about the quality and intensity of the patient's pain experience and about the pressure at which that pain experience is produced. Both routine x-ray imaging during the injection and post-injection CT examination of the injected discs are usually performed as part of the study. There are two diagnostic objectives: (1) to evaluate radiographically the extent of disc damage on discogram and (2) to characterize the pain response (if any) on disc injection to see if it compares with the typical pain symptoms the patient has been experiencing. Criteria exist to grade the degree of disc degeneration from none (normal disc) to severe. A symptomatic degenerative disc is considered one that disperses injected contrast in an abnormal, degenerative pattern, extending to the outer margins of the annulus and at the same time reproduces the patient's lower back complaints (concordance) at a low injection pressure. Discography is not a sensitive test for radiculopathy and has no role in its confirmation. It is, rather, a confirmatory test in the workup of axial back pain and its validity is intimately tied to its indications and performance. As stated,

it is the end of a diagnostic workup in a patient who has failed all reasonable conservative care and remains highly symptomatic. Its validity is enhanced (and only achieves potential meaningfulness) in the context of an MRI showing both dark discs and bright, normal discs -- both of which need testing as an internal validity measure. And the discogram needs to be performed according to contemporary diagnostic criteria -- namely, a positive response should be low pressure, concordant at equal to or greater than a VAS of 7/10 and demonstrate degenerative changes (dark disc) on MRI and the discogram with negative findings of at least one normal disc on MRI and discogram. See also functional anesthetic discography (FAD). Discography is not recommended in ODG. Patient selection criteria for discography if provider & payer agree to perform anyway:- Back pain of at least 3 months duration-Failure of recommended conservative treatment including active physical therapy- 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)-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)- 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.- Briefed on potential risks and benefits from discography and surgery- Single level testing (with control) (Colorado, 2001) - Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification."Regarding the request for lumbar discogram, ACOEM Practice Guidelines state 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, it should be reserved only for patients who meet the following criteria: Back pain of at least three months duration; Failure of conservative treatment; 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.); Is a candidate for surgery; Has been briefed on potential risks and benefits from discography and surgery. Therefore, in cases of request for discography, the onus is on the requesting provider to make the case for this procedure which has substantial literature against its use. In this injured worker, there does not appear to appropriate psychosocial screening prior to the request for discography. There is no documentation of satisfactory results from a detailed psychosocial assessment. Given this, the currently requested discography is not medically necessary.

**MRI Lumbar Spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI Topic.

**Decision rationale:** In the case of this injured worker, the request for an MRI is a repeat request. This was documented in a progress note on date of service October 7, 2014. The patient is getting a tearing sensation on his surgical incisions and is noted to have low back pain radiating to the right big toe and also to the left hip. The patient has a history of lumbar fusion and has a diagnosis of lumbar post laminectomy syndrome. The patient has noted weakness on the left's psoas and quadriceps muscle groups. The patient also has documentation of positive straight leg raise on the right-hand side. The last lumbar imaging was in May 2012. Therefore at this juncture with the documentation of "worsening numbness and tingling in his feet and toes" the request for a repeat lumbar MRI is medically necessary.

**Ambien 5mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Insomnia Treatment

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication

**Decision rationale:** Regarding the request for Zolpidem (Ambien), California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. The guidelines further state the failure of sleep disturbances to resolve in 7 to 10 days may indicate a psychiatric or medical illness. Within the documentation available for review, there is a lack of discussion indicating what behavioral treatments have been attempted for the condition of insomnia, and response to non-pharmacologic measures. In the absence of such documentation, the currently requested Zolpidem (Ambien) is not medically necessary.