

Case Number:	CM15-0009445		
Date Assigned:	01/27/2015	Date of Injury:	12/11/2010
Decision Date:	03/20/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/16/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 52 year old male who sustained an industrial injury reported on 12/11/2010. He has reported pain in the head, low back and knee. The diagnoses have included oblique tear of the right knee; concentric posterior annular tear with disc protrusion; facet hypertrophy with encroachment of the nerve roots in the lumbosacral regions; mild discogenic spondylosis; mild facet arthrosis in the lumbar region; and flattening of the lumbar lordosis. Treatments to date have included consultations; diagnostic imaging studies; acupuncture treatments; electromyogram and nerve conduction studies of the bilateral upper extremities (2/26/14); carpal tunnel release surgery (6/27/12 & 2/13/13); and medication management. The work status classification for this injured worker (IW) was noted to be temporarily totally disabled. On 12/16/2014 Utilization Review (UR) non-certified, for medical necessity, the request made on 12/9/2014, for continued acupuncture treatments of 2 x a week x 4 weeks; and follow-up with pain management for discogram. The Medical Treatment Utilization Schedule, chronic pain medical treatment and acupuncture medical treatment guidelines; and the American College of Occupational and Environmental Medicine Guidelines, low back complaints, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue acupuncture 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guideline Pain Outcomes and Endpoints Page(s): 13, 8-9.

Decision rationale: The patient presents with pain in the head, low back and knee. The request is for CONTINUE ACUPUNCTURE 2X4. The RFA provided is dated 11/25/14. The diagnoses have included oblique tear of the right knee; concentric posterior annular tear with disc protrusion; facet hypertrophy with encroachment of the nerve roots in the lumbosacral regions; mild discogenic spondylosis; mild facet arthrosis in the lumbar region; and flattening of the lumbar lordosis. Treatments to date have included consultations; diagnostic imaging studies; acupuncture treatments; electromyogram and nerve conduction studies of the bilateral upper extremities (2/26/14); carpal tunnel release surgery (6/27/12 & 2/13/13); and medication management. The patient is temporarily totally disabled. MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. MTUS page 8 also requires that the treater monitor the treatment progress to determine appropriate course of treatments. For additional treatment, MTUS Guidelines require functional improvement as defined by Labor Code 9792.20(e), a significant improvement in ADLs, or change in work status and reduced dependence on medical treatments. Per progress report dated 11/25/14, the patient has previously completed unknown number of acupuncture sessions. MTUS requires documentation of functional improvement, defined by labor code 9792.20(e) as significant change in ADL's, or change in work status and reduced dependence on other medical treatments. In this case, treater has not documented functional improvement. There are no discussions regarding ADL's and reduction in medication use. Therefore, the request IS NOT medically necessary.

Follow-up with pain management for discogram: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Discography'

Decision rationale: The patient presents with pain in the head, low back and knee. The request is for FOLLOW UP WITH PAIN MANAGEMENT FOR DISCOGRAM. The RFA provided is dated 11/25/14. The diagnoses have included oblique tear of the right knee; concentric posterior annular tear with disc protrusion; facet hypertrophy with encroachment of the nerve roots in the lumbosacral regions; mild discogenic spondylosis; mild facet arthrosis in the lumbar region; and flattening of the lumbar lordosis. Treatments to date have included consultations; diagnostic

imaging studies; acupuncture treatments; electromyogram and nerve conduction studies of the bilateral upper extremities (2/26/14); carpal tunnel release surgery (6/27/12 & 2/13/13); and medication management. The patient is temporarily totally disabled. ACOEM guidelines p304 does not support discogram as a preoperative indication for fusion as "discography does not identify the symptomatic high-intensity zone, and concordance of symptoms with the disk injected is of limited diagnostic value." ODG guidelines, chapter 'Low Back Lumbar & Thoracic (Acute & Chronic)' and topic 'Discography' states that Discography is Not Recommended in ODG. Patient selection criteria for Discography if provider & payor agree to perform anyway: (a) Back pain of at least 3 months duration (b) Failure of recommended conservative treatment including active physical therapy (c) 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) (d) 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) (e) 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. (f) Briefed on potential risks and benefits from discography and surgery (g) Single level testing (with control) (Colorado, 2001) (h) Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification. In this case, the patient has had chronic pain and has not benefited from conservative therapy; however, review of the medical record does not clearly demonstrate the medical necessity for the request. The discogram may serve as a screening tool to assist surgical decision making if fusion surgery is indicated. In this case, there is no discussion in relation to a possible surgical intervention either. Discography is not supported for identification of pain. Given the limited provided information, the request cannot be considered to be in accordance with the above referenced guidelines. The request IS NOT medically necessary.