

<b>Case Number:</b>	CM15-0015818		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	12/04/2003
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2015

### 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 46 year old female, who sustained an industrial injury on 12/4/2003. She reports low back pain and neck pain. Diagnoses include status post anterior lumbar 5 to sacral 1 discectomy and fusion. Treatments to date include TENS (transcutaneous electrical nerve stimulation), physical therapy and medication management. A progress note from the treating provider dated 12/19/2014 indicates the injured worker reported low back pain with left leg pain. On 12/31/2014, Utilization Review non-certified the request for a discogram of lumbar 3-5, computed tomography scan for thoracic 12 to sacral 1 and a prescription of Vicodin, citing MTUS and ACOEM.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Discogram L3-4 and L4-5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304, 305 and 66.

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

**Decision rationale:** The 46 year old patient presents with low back pain, rated at 8/10, that radiates to the leg, as per progress report dated 12/19/14. The request is for DISCOGRAM L3-4 AND L4-5. The RFA for the case is dated 12/03/14, and the patient's date of injury is 12/04/03. The patient is status post L5-S1 fusion, and status post cervical fusion, as per progress report dated 12/19/14. She has also been diagnosed with reactive depression. Medications include Norco, Lyrica, Duexis, Tramadol, Lunesta, Neurontin, Amitiza, Butrans and Cymbalta. CT scan of the lumbar spine, dated 12/17/14, revealed post-operative changes at L5-S1, detroscoliosis with mild degenerative disc disease, L4-5 mild-to-moderate canal stenosis with moderate bilateral neural foraminal narrowing, and minimal grade anterolisthesis at L3-4 and L4-5. None of the progress reports document the patient's work status. 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 undergone a CT scan of the lumbar spine on 12/17/14 which revealed degeneration at L5-S1 along with protrusion into the spinal canal. However, the imaging study did not confirm the cause of the ongoing pain. The treater has, therefore, requested for a discogram followed by CT scan because "there is no other way of analyzing the condition or structure of L4-5 disc," as per report dated 12/17/14. The treater believes that an MRI will be ineffective due to the presence of a metallic artifact at L5-S1, and no other tests are available to show the structural changes at L4-5. However, there is no discussion in relation to a possible surgical intervention. Discography is not supported for identification of pain. Hence, the request IS NOT medically necessary.

## **1 CT scan from T12 to S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back, Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low back Chapter under CT scans.

**Decision rationale:** The 46 year old patient presents with low back pain, rated at 8/10, that radiates to the leg, as per progress report dated 12/19/14. The request is for 1 CT SCAN FROM T12 TO S1. The RFA for the case is dated 12/03/14, and the patient's date of injury is 12/04/03. The patient is status post L5-S1 fusion, and status post cervical fusion, as per progress report dated 12/19/14. She has also been diagnosed with reactive depression. Medications include Norco, Lyrica, Duexis, Tramadol, Lunesta, Neurontin, Amitiza, Butrans and Cymbalta. CT scan of the lumbar spine, dated 12/17/14, revealed post-operative changes at L5-S1, detroscoliosis with mild degenerative disc disease, L4-5 mild-to-moderate canal stenosis with moderate bilateral neural foraminal narrowing, and minimal grade anterolisthesis at L3-4 and L4-5. None of the progress reports document the patient's work status. ODG guidelines, Low back Chapter under CT scans of the lumbar spine states: "Not recommended except for indications below for CT. Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Indications for imaging: - Thoracic spine trauma: equivocal or positive plain films, no neurological deficit - Thoracic spine trauma: with neurological deficit, - Lumbar spine trauma: trauma, neurological deficit - Lumbar spine trauma: seat belt -chance- fracture - Myelopathy -neurological deficit related to the spinal cord-, traumatic - Myelopathy, infectious disease patient - Evaluate pars defect not identified on plain x-rays - Evaluate successful fusion if plain x-rays do not confirm fusion." In this case, the patient has undergone a CT scan of the lumbar spine on 12/17/14 which revealed degeneration at L5-S1 along with protrusion into the spinal canal. However, the imaging study did not confirm the cause of the ongoing pain. The treater has requested for a discogram followed by CT scan because "there is no other way of analyzing the condition or structure of L4-5 disc," as per report dated 12/17/14. CT is typically done with discogram, and is part of the procedure. However, the UR mentions it as a separate request. ODG does not recommend CT scan of the lumbar spine unless there is lumbar spine trauma with neurologic deficit, or seat belt trauma with chance of fracture. There is no documentation that patient presents with aforementioned indications. Therefore, the request IS NOT medically necessary.

## **Unknown prescription of Vicodin: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** The 46 year old patient presents with low back pain, rated at 8/10, that radiates to the leg, as per progress report dated 12/19/14. The request is for UNKNOWN PRESCRIPTION OF VICODIN. The RFA for the case is dated 12/03/14, and the patient's date of injury is 12/04/03. The patient is status post L5-S1 fusion, and status post cervical fusion, as per progress report dated 12/19/14. She has also been diagnosed with reactive depression. Medications include Norco, Lyrica, Duexis, Tramadol, Lunesta, Neurontin, Amitiza, Butrans and Cymbalta. CT scan of the lumbar spine, dated 12/17/14, revealed post-operative changes at L5-S1, detroscoliosis with mild degenerative disc disease, L4-5 mild-to-moderate canal stenosis with moderate bilateral neural foraminal narrowing, and minimal grade anterolisthesis at L3-4 and L4-5. None of the progress reports document the patient's work status. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, none of the available progress reports document the use of Vicodin. However, in progress report dated 11/20/14, the treater states that the patient's Norco was denied, and this led to "unnecessary pain and suffering." The treater is, therefore, requesting for Vicodin as it is a "separate medication different from Norco." The patient is also using Tramadol (another opioid) for pain relief. The treater, however, does not document the impact of prior opioid therapy on pain using a validated scale neither does the treater demonstrate a measurable increase in function due to opioid use. No UDS and CURES reports are available for review. The treater does not discuss the side effects of opioids in this patient. MTUS requires specific discussion about 4As, including analgesia, ADLs, adverse side effects, and aberrant behavior, for prolonged use. Additionally, the request does not include the quantity. Hence, the request IS NOT medically necessary.