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| Case Number: | CM15-0132721 | | |
| Date Assigned: | 07/20/2015 | Date of Injury: | 11/03/2011 |
| Decision Date: | 08/19/2015 | UR Denial Date: | 06/26/2015 |
| Priority: | Standard | Application Received: | 07/09/2015 |

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 44 year old male who sustained an industrial injury on November 3, 2011. He complains of a side effect with Butrans patch and has been diagnosed with adjacent segment degeneration L3-4 with moderate right foraminal and lateral recess stenosis, mild left, status post L4-5 posterior spinal instrumentation and fusion, bilateral laminectomies, posterior psuedoarthrosis L4-5, right leg radiculopathy, lateral recess stenosis L5-S1, right L4 and S1 radiculopathy, status post L4-5 direct lateral fusion with instrumentation, and status post L4-5 discectomy x 2. Treatment has included medications, medical imaging, epidural steroid injection, ice, physical therapy, and trigger point injections. There was tenderness to palpation centrally in the low lumbar spine above his well healed mid line lumbar spine incision. There was pain with extension, improved with forward flexion. The treatment request included diagnostic discogram at L3-4 with negative control, chiropractic treatment, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic Discogram at L3-L4 with Negative Control: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Discography.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic (Acute & Chronic) Chapter under Discography.

Decision rationale: The patient presents with pain in the low back and bilateral lower extremities. The request is for DIAGNOSTIC DISCOGRAM AT L3-L4 WITH NEGATIVE CONTROL. Patient is status post lumbar spine surgery 12/19/13. Physical examination to the lumbar spine on 05/26/13 revealed tenderness to palpation over the lumbar facets bilaterally, right sacroiliac joint, thoracolumbar spasm bilaterally. Straight leg raising test was positive at 60 degrees. Patient's treatments have included medications, lumbar ESIs, ice treatment, physical therapy, MRI and X-rays of the lumbar spine, and trigger point injection. Per 05/13/15 progress report, patient's diagnosis include status post L4-L5 posterior spinal instrumentation and fusion, bilateral L4-S1 laminotomies 12/19/13, posterior pseudarthrosis L4-5, right leg radiculopathy, resolved, lateral recess stenosis L5-S1, right L4 and S1 radiculopathy, status post L4-5 discectomy x 2, status post L4-5 direct lateral fusion with instrumentation. Patient's medications, per 04/28/15 progress report include Butrans, Zofran, Tramadol, Naprosyn, Zolof, Seroquel, and Clonidine. Patient is permanent and stationary. ACOEM guidelines p 304 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, Low Back-Lumbar & Thoracic (Acute & Chronic) Chapter under Discography states: Not Recommended. 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 progress report dated 06/05/15, treater's reason for the request is to identify the patient's pain generator. Patient has been suffering with pain in the low back and bilateral lower extremities despite prior surgery. However, the guidelines do not support discography for pre-operative measure or to identify pain

generator unless lumbar surgery is a realistic possibility. This patient does not present with indications for lumbar fusion surgery as there is lack of instability, dislocation, fractures, etc. The request IS NOT medically necessary.

Chiropractic Treatment two (2) times a week for three (3) weeks for the lumbar area:

Overtured

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy Page(s): 58-59.

Decision rationale: The patient presents with pain in the low back and bilateral lower extremities. The request is for CHIROPRACTIC TREATMENT TWO (2) TIMES A WEEK FOR THREE (3) WEEKS FOR THE LUMBAR AREA. Patient is status post lumbar spine surgery 12/19/13. Physical examination to the lumbar spine on 05/26/13 revealed tenderness to palpation over the lumbar facets bilaterally, right sacroiliac joint, thoracolumbar spasm bilaterally. Straight leg raising test was positive at 60 degrees. Patient's treatments have included medications, lumbar ESIs, ice treatment, physical therapy, MRI and X-rays of the lumbar spine, and trigger point injection. Per 05/13/15 progress report, patient's diagnosis include status post L4-L5 posterior spinal instrumentation and fusion, bilateral L4-S1 laminotomies 12/19/13, posterior pseudarthrosis L4-5, right leg radiculopathy, resolved, lateral recess stenosis L5-S1, right L4 and S1 radiculopathy, status post L4-5 discectomy x 2, status post L4-5 direct lateral fusion with instrumentation. Patient's medications, per 04/28/15 progress report include Butrans, Zofran, Tramadol, Naprosyn, Zoloft, Seroquel, and Clondicine. Patient is permanent and stationary. 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. Treater has not discussed this request. Review of the medical records did not indicate prior chiropractic treatment. The patient suffers from pain in the low back and bilateral lower extremities. Given the patient's diagnosis, a short course of 6 sessions would be reasonable. The request for 6 sessions of chiropractic therapy is in line with guideline recommendations and therefore, it IS medically necessary.