

Case Number:	CM15-0132968		
Date Assigned:	07/21/2015	Date of Injury:	11/30/2005
Decision Date:	08/21/2015	UR Denial Date:	06/30/2015
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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 40-year-old female who sustained an industrial injury on 11/30/05. Injury occurred when she slipped and fell on ice. Past surgical history was positive for gastric bypass surgery. The 4/9/14 lumbar spine MRI impression documented mild annular disc bulge at L3/4 with mild central canal narrowing but no nerve root compression. There was moderate degenerative disc disease at L5/S1 with mild annular disc bulge and moderate left foraminal narrowing. Conservative treatment included medications, physical therapy, injections, and activity modification. She underwent right L4/5 and L5/S1 epidural steroid injection on 12/29/14 which only lasted a few days. The 6/1/15 treating physician report indicated that thoracic injured worker had an epidural injection with some relief. She was using Fentanyl patches every 48 hours. Physical exam documented antalgic gait with some restricted lumbosacral range of motion. Neurologic exam documented patchy sensory changes, diminished reflexes, and limited straight leg raise test. The impression was significant back with radicular pain, failing conservative efforts, annular disruption and painful disc L4/5 and L5/S1. The treatment plan recommended lumbar discography for pre-operative planning to proceed with interbody fusion at L4/5 and L5/S1. Alternative treatment options including spinal cord stimulator trial to control symptoms and avoid the major fusion surgery. Authorization was requested for spinal cord stimulator trial, discography, and CT scan to follow discography. The 6/30/15 utilization review non-certified the request for spinal cord stimulator trial as the injured worker did not meet guidelines criteria relative to previous lumbar spine surgery or complex regional pain syndrome.

The requests for discography and follow-up CT scan were non-certified as studies indicate discography to be of limited diagnostic value.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Indications for stimulator implantation Page(s): 106.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

Decision rationale: The California MTUS recommend the use of spinal cord stimulator only for selected patients in cases when less invasive procedures have failed or are contraindicated. Indications included failed back syndrome, defined as persistent pain in patients who have undergone at least one previous back surgery, and complex regional pain syndrome. Consideration of permanent implantation requires a successful temporary trial, preceded by psychological clearance. Guideline criteria have not been met. This injured worker has not undergone back surgery nor been diagnosed with complex regional pain syndrome. Additionally, there is no evidence of a psychological evaluation. Therefore, this request is not medically necessary.

Discography: 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 Chapter, Updated 05/15/15, Discograms: Discography.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Discography and Other Medical Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007), page(s) 138-139.

Decision rationale: The California MTUS guidelines indicate that there is a lack of strong medical evidence supporting discography and should only be considered for patients who meet specific criteria. Indications include back pain of at least 3 months duration, failure of conservative treatment, satisfactory results from a detailed psychosocial assessment, is a candidate for surgery, and has been briefed on potential risks and benefits from discography and surgery. The updated ACOEM low back guidelines state that discography is not recommended for acute, sub-acute, and chronic lower back pain or radicular pain syndromes. The Official Disability Guidelines state that discography is not recommended and of limited diagnostic value. Guideline criteria have not been met. This injured worker presents with low back radicular pain.

Clinical exam findings are non-specific and not able to be correlated with imaging findings of disc pathology at L3/4 and L5/S1. There is no evidence of a psychosocial assessment or that the injured worker is a candidate for surgery. Discogram outcomes have not been found to be consistently reliable for the low back, based upon recent studies. There are insufficient large-scale, randomized, controlled references showing the reliability of the requested study in this patient's clinical scenario. There is no compelling reason to support the medical necessity of this request in the absence of guideline support. Therefore, this request for is not medically necessary.

CT to follow Discography: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.