

Case Number:	CM15-0189134		
Date Assigned:	10/01/2015	Date of Injury:	12/01/2005
Decision Date:	11/09/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/25/2015

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 55-year-old male who sustained an industrial injury on 12/1/05, relative to a slip and fall. Conservative treatment had included occasional chiropractic treatment, physical therapy, medications, medial branch blocks, epidural steroid injection, and aquatic therapy. The 4/7/15 lumbar spine MRI impression documented a 5 mm L3/4 posterior disc protrusion causing moderate stenosis and impinging on the L3 nerve root. At L4/5, there was a 4.3 mm posterior disc protrusion with moderate foraminal stenosis. At L5/S1, there was an osteophyte with marked narrowing indicative of spondylosis, hypertrophic changes, and marked foraminal stenosis. The lumbar spine x-ray impression documented multilevel moderate spondylosis, L4/5 and L5/S1 facet hypertrophy, straightening of the lumbar lordotic curve with muscle spasms, and marked narrowing of the L5/S1 disc space, as well as osteophyte formation indicative of spondylosis and discogenic disease. The 7/29/15 cited grade 6-7/10 low back pain radiating into both buttocks and hips, with muscle spasms and occasional tingling in the left lower extremity. Pain increased with activities. Physical exam documented lumbar paraspinal and parathoracic tenderness, moderate loss of range of motion, symmetric lower extremity deep tendon reflexes, mildly decreased lateral heel sensation, mildly decreased bilateral ankle dorsiflexion and plantar flexion and great toe dorsiflexion strength, and positive straight leg raise. The 8/26/15 treating physician report cited chronic grade 7/10 low back pain. There was imaging evidence of 3 disc herniations at L3/4, L4/5 and L5/S1, and spondylosis at L4/5 and L5/S1. Conservative treatment with facet rhizotomies and epidural steroid injection had not provided significant improvement. Physical exam documented lumbar midline, paraspinal, buttocks tenderness, and limited lumbar flexion. There was normal lower extremity strength. Gait was within normal limits. The diagnosis was lumbosacral spondylosis without

myelopathy. Authorization was requested for lumbar discogram with laser percutaneous disc decompression (PDD) discectomy at L4/5 and L5/S1 under anesthesia with fluoroscopic guidance. The 9/2/15 utilization review non-certified the request for lumbar discogram with laser percutaneous disc decompression (PDD) discectomy at L4/5 and L5/S1 under anesthesia with fluoroscopic guidance as both procedures were not recommended by guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar discogram with laser percutaneous disc decompression (PDD) discectomy at L4-5 and L5-S1 under anesthesia with fluoro guidance.: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Integrated Treatment/Disability Duration Guidelines Low Back & Lumbar & Thoracic (acute & chronic).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar & Thoracic: Discography; Mild® (minimally invasive lumbar decompression); Percutaneous discectomy (PCD).

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 Official Disability Guidelines state that discography is not recommended and of limited diagnostic value. The California MTUS guidelines do not recommend percutaneous endoscopic laser discectomy and state these procedures should be regarded as experimental at this time. The Official Disability Guidelines state that minimally invasive lumbar decompression and percutaneous discectomy are not recommended, since proof of its effectiveness has not been demonstrated. Guidelines stated that percutaneous lumbar discectomy procedures are rarely performed in the [REDACTED], and no studies have demonstrated the procedure to be as effective as discectomy or microsurgical discectomy. Guideline criteria have not been met. 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 discogram in this patient's clinical scenario. A psychosocial assessment is not evidenced. There is no evidence to support the effectiveness of percutaneous lumbar discectomy procedures over discectomy or microsurgical discectomy. There is no compelling reason to support the medical necessity of this request in the absence of guideline support for either procedure. Therefore, this request is not medically necessary.