

Case Number:	CM14-0187552		
Date Assigned:	11/17/2014	Date of Injury:	08/03/2009
Decision Date:	01/06/2015	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	11/10/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 sustained a work related injury on August 3, 2009. The exact mechanism of the work related injury was not provided in the documentation submitted for review. A MRI of the lumbar spine dated December 16, 2013, noted a central protrusion and annular tear at the L4-L5 disc space. On July 18, 2014, a physician follow up note described the injured worker with left lower extremity radiating pain, taking a combination of oxycodone and an anti-inflammatory, having undergone a discogram noted to be negative. A new patient progress note dated October 7, 2014, noted the injured worker with lower back pain for over thirty years with radicular pain. The Physician noted the injured worker had a rhizotomy and radiofrequency ablation without improvement. The procedure reports were not included in the provided documentation. Epidurals were noted to have provided some transient relief. The diagnoses were noted to include low back pain, and lumbar degenerative disc disease. The Physician requested authorization for a Discography L4/5 and L5/S1 and left L4/5 and L5/S1 Transforaminal Epidural with Cytonics Alpha-2 Macroglobulin harvesting and treatment under anesthesia. On October 17, 2014, Utilization Review evaluated the request for a Discography L4/5 and L5/S1 and left L4/5 and L5/S1 Transforaminal Epidural with Cytonics Alpha-2 Macroglobulin harvesting and treatment under anesthesia, citing MTUS Chronic Pain Medical Treatment Guidelines, MTUS American College of Occupational and Environmental Medicine (ACOEM) Chapter 12, the Official Disability Guidelines (ODG-TWC) Low Back Procedure Summary last updated May 12, 2014, and Bone Joint Res. August 2013, 2(8): 169-178). The UR Physician noted the injured worker had a prior discogram, with no indication of the levels requested for the discogram and no validity for use. The injured worker was noted to have undergone prior ESI's with poor response, therefore the criteria for repeat injections was not met. The UR Physician noted that there was no research to indicate that the use of cell-based therapies

to treat intervertebral disc degeneration had undergone FDA approval, therefore the medical necessity of the harvesting and treatment was not established. The UR Physician recommended non-certification of the entire request. The decision was subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Discography L4/5 and L5/S1 and Left L4/5 and L5/S1 Transforaminal Epidural with Cytonics Alpha-2 Macroglobulin Harvesting and Treatment under Anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS low back pain chapter, ODG low back pain chapter

Decision rationale: Discography is attest as performed prior to lumbar fusion. This patient does not meet criteria for lumbar fusion. Is no documentation of instability fracture or tumor. Since lumbar fusion surgery is not medically necessary, then discography is not needed. The patient does not meet criteria for repeat transforaminal epidural injection. Patient a previous Epidural Injections without documented benefit. Criteria for additional Epidural Steroid Injections are not met. Therefore, the requested Discography L4/5 and L5/S1 and Left L4/5 and L5/S1 Transforaminal Epidural with Cytonics Alpha-2 Macroglobulin Harvesting and Treatment under Anesthesia are not medically necessary.