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| Case Number: | CM14-0215461 | | |
| Date Assigned: | 01/05/2015 | Date of Injury: | 03/12/2002 |
| Decision Date: | 02/28/2015 | UR Denial Date: | 12/19/2014 |
| Priority: | Standard | Application Received: | 12/23/2014 |

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. 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:

This patient is a 58-year-old male with an injury date of 3/12/02. No PR2 was submitted with the treatment request. Based on the 8/28/14 orthopedic qualified medical reevaluation, this patient complains of constant cervical and lumbosacral pain with “right posterior hip pain that is occasional and moderat” and “electric sensation over the lateral aspect of the right calf extending to the right toe with numbness over the left ring and little toes.” Exam shows significant paravertebral spasm, guarding, and asymmetric range of motion. Hip internal rotation of 20/30 (current/normal). Sensation testing revealed hypersensitivity over the lateral aspect of the right tibia and decreased sensation over the left ring and little toes and the plantar-lateral aspect of the left foot. Palpation of the left radial mid forearm created a sensation extending to the thumb and index fingers. Referenced, recent diagnostics: 7/23/12: Xray of lumbosacral spine showed no significant changes from 2/10/11. 10/4/12: Cervical spine MRI showed broad-based disc osteophyte complex C4-5 with impingement of cord with canal stenosis and moderate to severe scattered neural foraminal narrowing at multiple levels secondary to uncovertebral and articular facet degeneration. 5/19/13: Lumbar spine MRI showed degenerative disc disease with stenosis. 5/30/13: Xray showed bilateral hip joint space narrowing consistent with osteoarthritis. Diagnostic impressions for this patient are: 1. Status post lumbosacral surgery with L5-S1 fusion and L4-L5 artificial disc, 12/7/10. 2. History of grade I L5-S1 spondylolytic spondylolisthesis. 3. Status post right total hip arthroplasty, 1/12/05. 4. Status post right hip revision arthroplasty with revision of the femoral head and acetabular liner, 7/11/08. 5. Pre-existing hip degenerative osteoarthritis. 6. Alleged cervical musculoligamentous strain/sprain,

not industrially-related. The utilization review being challenged is dated 12/19/14. The request is for inject for spine disk x-ray. The requesting provider has provided various reports from 7/8/13 to 10/7/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3, L2 lumbar discogram: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Low back discography

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back, Discography, online

Decision rationale: This patient presents constant cervical and lumbar pain. The treater requests INJECT FOR SPINE DISK X-RAY; however, no PR2 was submitted with the treatment request. Discography is not recommended by ODG guidelines. However, it is the end of a diagnostic workup in a patient who has failed all reasonable conservative care and remains highly symptomatic and if provider and payor agree to perform anyway, the following criteria must be met: Back pain -3 months duration, failure of recommended conservative treatment (including active PT), MRI demonstrating one or more degenerated and normal discs to allow for an internal control injection, satisfactory results from detailed psychosocial assessment, as a confirmatory tool in preparation for a surgical procedure, briefing of potential risk and benefits, and single level testing. This patient is s/p lumbosacral surgery with L5-S1 fusion and L4-L5 artificial disc on 12/7/10. The 10/4/12 MRI study showed broad-based disc osteophyte complex C4-5 with impingement of the cord with central canal stenosis with moderate to severe. Per the 8/27/14, the treater wants to get an MRI to evaluate for disc herniation and transitional syndrome because of the persistent left sided pain and pain radiating anteriorly. However, due to high rates of positive discogram after surgery for lumbar disc herniation, ODG guidelines state, this should be potential reason for non-certification. The 5/20/14 also notes this patient has had depression and anxiety but has not had any treatment, furthermore, there is no evidence or documentation of a detailed psychosocial assessment conducted in review of submitted reports as required by ODG guidelines. Cervical/lumbar/hip surgery is not anticipated in the near future for this patient per the examiner. Additionally, documentation in reviewed records fails to meet the criteria as established by ODG guidelines for a discogram. Therefore, the request IS NOT medically necessary.