

Case Number:	CM15-0116868		
Date Assigned:	06/25/2015	Date of Injury:	11/03/2014
Decision Date:	07/24/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/17/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 32 year old male who sustained a work related injury November 3, 2014. While picking up a 5-gallon paint bucket, he felt a sharp pain in his low back. He was treated with a back brace, medications, physical therapy, and x-rays. An MRI of the lumbar spine, dated December 9, 2014 (report present in the medical record), revealed at L4-L5 a 3 mm disc protrusion with mild central canal stenosis. According to a treating physician's notes, dated May 11, 2015, the injured worker presented with complaints of low back pain, 7-8/10, with lower extremity pain, numbness and tingling. The pain radiates to the posterolateral thighs into his legs and feet, right greater than left. He has completed 24 sessions of physical therapy. Physical examination revealed; able to heel walk and difficulty with toe walk due to discomfort, normal gait, tenderness to palpation to paravertebral musculature and midline, limited range of motion to the spine, and pain with extension but especially with flexion. Diagnoses are persistent low back pain with intermittent lower extremity pain; sciatica in the setting of L4-L5 disc degeneration with disc herniation and annular tear. At issue, is the request for authorization for a lumbar discogram with CT L3-L4 and L4-L5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar discogram with CT, L3-L4 and L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Discography, http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm.

Decision rationale: According to ODG guidelines, discography not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) is of limited diagnostic value. (Pain production was found to be common in non-back pain patients, pain reproduction was found to be inaccurate in many patients with chronic back pain and abnormal psychosocial testing, and in this latter patient type, the test itself was sometimes found to produce significant symptoms in non-back pain controls more than a year after testing.) Also, the findings of discography have not been shown to consistently correlate well with the finding of a High Intensity Zone (HIZ) on MRI. Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not allow fusion). Discography may help distinguish asymptomatic discs among morphologically abnormal discs in patients without psychosocial issues. Precise prospective categorization of discographic diagnoses may predict outcomes from treatment, surgical or otherwise. Invasive diagnostics such as provocative discography have not been proven to be accurate for diagnosing various spinal conditions, and their ability to effectively guide therapeutic choices and improve ultimate patient outcomes is uncertain. (Chou, 2008) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. (Cohen, 2005) Provocative discography is not recommended because its diagnostic accuracy remains uncertain, false-positives can occur in persons without low back pain, and its use has not been shown to improve clinical outcomes. (Chou2, 2009) This recent RCT concluded that, compared with discography, injection of a small amount of bupivacaine into the painful disc was a better tool for the diagnosis of discogenic LBP. (Ohtori, 2009) Discography may cause disc degeneration. Even modern discography techniques using small gauge needle and limited pressurization resulted in accelerated disc degeneration (35% in the discography group compared to 14% in the control group), disc herniation, loss of disc height and signal and the development of reactive endplate changes compared to match-controls. These findings are of concern for several reasons. Discography as a diagnostic test is controversial and in view of these findings the utility of this test should be reviewed. Furthermore, discography in current practice will often include injecting discs with a low probability of being symptomatic in an effort to validate other disc injections, a so-called control disc. Although this strategy has never been confirmed to increase test validity or utility, injecting normal discs even with small gauge needles appears to increase the rate of degeneration in these discs over time. The phenomenon of accelerated adjacent segment degeneration adjacent to fusion levels may be, in part, explained by previous

disc puncture if discography was used in segments adjacent to the fusion. Similarly, intradiscal therapeutic strategies (injecting steroids, sclerosing agents, growth factors, etc.) have been proposed as a method to treat, arrest or prevent symptomatic disc disease. Discography is not a sensitive test for radiculopathy and has no role in its confirmation. It is, rather, a confirmatory test in the workup of axial back pain and its validity is intimately tied to its indications and performance. As stated, it is the end of a diagnostic workup in a patient who has failed all reasonable conservative care and remains highly symptomatic. Its validity is enhanced (and only achieves potential meaningfulness) in the context of an MRI showing both dark discs and bright, normal discs -- both of which need testing as an internal validity measure. And the discogram needs to be performed according to contemporary diagnostic criteria -- namely, a positive response should be low pressure, concordant at equal to or greater than a VAS of 7/10 and demonstrate degenerative changes (dark disc) on MRI and the discogram with negative findings of at least one normal disc on MRI and discogram. See also Functional anesthetic discography (FAD). Discography is Not Recommended in ODG. Discography is not recommended for acute back pain. There is no documentation that the patient is candidate for surgery. Therefore, the request for Lumbar discogram with CT, L3-L4 and L4-L5 is not medically necessary.