

Case Number:	CM14-0100324		
Date Assigned:	07/30/2014	Date of Injury:	10/30/2013
Decision Date:	08/29/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	06/30/2014

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 Orthopaedic Surgery and is licensed to practice in California. 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:

This 75-year-old male sustained an industrial injury on 10/30/13. The injury occurred when a 750-pound gate fell on him and crushed his chest and back. He was diagnosed with an L4 compression fracture, sternal fracture with mediastinal hematoma, right inferior/superior pubic rami fracture, and L1 vertebral fracture. He underwent posterior instrumentation L3 through L5 with posterolateral fusion on 10/31/13. He had been wearing a back brace since surgery. The 02/28/14 lumbar MRI findings were significant for mild narrowing of the bilateral recess at L4/5, 3 mm spondylolisthesis at L4/5, compression fracture at L1, and instrumentation from L3 through L5. The 3/14/14 lumbar CT scan impression documented L1 anterior wedge compression fracture with 40% loss of height and visible fracture line in the superior endplate of L1 that does not extend into the pedicles. There was an L4 compression fracture with 50% loss of height centrally and a visible fracture line in the inferior endplate of L4 extending to the central aspect of the vertebral body. There was endplate sclerosis in the location of the previously noted fracture involving the right aspect of the inferior endplate of L2. There was posterior spinal instrumentation from L3 to L5 without evidence for hardware related complication. There was bilateral posterolateral fusion from L3 to L5 with appropriate signs of fusion. There was mild narrowing of the left lateral recess and mild to moderate right neuroforaminal narrowing at the L2/3 level. There was moderate narrowing of both lateral recesses at the L4/5 level with a 3 mm grade 1 anterolisthesis of L4 on L5. There was mild bilateral neuroforaminal narrowing at L5/S1. There was mild levoscoliosis of the lumbar spine with the apex centered at the L2 level and a Cobb angle of 6%. The 3/18/14 treating physician report cited back pain radiating to the lower extremities, right worse than left. The patient was unable to stand for more than 10 minutes or walk more than one half block. He was using a cane or crutches to walk. His symptoms were gradually worsening and the right leg was giving out on

him. A physical exam documented 4-/5 bilateral hip flexion and right knee extension strength and decreased sensation over the right lateral shin. There was moderate to severe tenderness to palpation of the mid to lower lumbar spine. The treating physician indicated the CT scan revealed pseudoarthrosis at L3/4 and L4/5. The 5/16/14 treating physician report cited back and right leg pain. His symptoms have not improved with lumbar injections. His physical exam documented 4-/5 right dorsiflexion and plantar flexion strength. The diagnosis was failed back syndrome, lumbar stenosis and lumbar pseudoarthrosis. The patient had stenosis of L4/5. He underwent fusion with instrumentation at the L4/5 level with incomplete decompression. The patient required exploration of fusion and redo decompression with re-instrumentation and extension of fusion to L5/S1 to address his L5 radiculopathy, mechanical back pain and lumbar stenosis. The 06/25/14 utilization review denied the request for lumbar surgery as neither the CT scan nor MRI showed a pseudoarthrosis or solid fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery Explore Fusion Redo Decompression with Reinstrumentation L2-S1, Back:
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 202-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Fusion (Spinal).

Decision rationale: The ACOEM revised low back guidelines do not provide specific recommendations for revision decompression and re-instrumentation. The Official Disability Guidelines (ODG) recommends revision surgery for failed previous operations if significant functional gains are anticipated. Revision surgery for the purposes of pain relief must be approached with extreme caution due to less than 50% success rate reported in medical literature. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. There is no imaging evidence of pseudoarthrosis noted on the 3/14/14 CT scan. There is spotty global weakness of the lower extremities noted on the physical exams of 3/18/14 and 5/16/14. There is no electrodiagnostic evidence of specific nerve root radiculopathy. There is no imaging documentation of nerve root compromise. There is no radiographic evidence of spinal instability. Psychosocial screening is not evident. Therefore, this request for back surgery to explore the fusion, redo decompression with re-instrumentation L2-S1, is not medically necessary.