

Case Number:	CM14-0088056		
Date Assigned:	07/23/2014	Date of Injury:	01/22/1991
Decision Date:	09/29/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	06/11/2014

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 Texas. 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 is a 58 year old female who had a work related injury on 01/22/91. She apparently fell over a cable onto the edge of concrete and then a coworker fell on top of her. Since then she has had subsequent chronic low back pain for which she had had prior surgeries including an L5-S1 fusion with subsequent heterotopic ossification following transforaminal lumbar interbody fusion at L5-S1 and then redo left L5-S1 hemilaminotomy, medial facetectomy, foraminotomy, and interlaminar decompression with resection of scarring. Decompression of the left L5 and S1 nerve roots. The injured worker has left lower extremity chronic regional pain syndrome with a new onset of neurologic deficits and increased pain in the left lower extremity after undergoing lumbar sympathetic block on 09/12/12, with otherwise negative extensive neurologic workup. Initial MRI of the thoracic and lumbar spine did not reveal any significant abnormalities or acute changes to explain this weakness. CT scan of the pelvis did not reveal any hematoma or abnormal mass. EMG showed chronic radiculopathy changes in bilateral L5-S1 distribution, with no acute active neuropathic process. Additionally, she had MRI of the brain, which was unremarkable. New onset of right lower extremity pain in January of 2014, status post hospitalization with new imaging and bilateral L5 selective nerve root block as well as L4-5 facet injections. The most recent documentation submitted for review is dated 05/12/14; the injured worker is in on a consult because of severe back pain. She is noted to have failed conservative management, therapy, exercises as well as injections. On physical examination, reveals 3+ spasms in her paralumbar region with a well-healed incision posteriorly. She has very limited range of motion secondary to pain. She can barely get out of bed. Her left lower extremity has severe dysesthetic pain syndrome and sensitivity to the skin with sensory loss and hypoesthesia. Her L5 weakness is about 4/5 or 4-/5 in the left lower extremity, and gastrocnemius weakness is 5-/5. The right lower extremity appears to be strong. CT scan done

on 05/11/14 of the lumbar spine demonstrates a definite nonunion, non-osseous fusion at L5-S1. There is a complete crack through the entire graft segment at L5-S1. This needs to be re-fused. There is significant foraminal stenosis but with heterotopic ossification of bone and foraminal stenosis. L4-5 shows facet arthropathy and pain likely related to those facets. The recommendation was the injured worker needs to have revision fusion. Anterior and lumbar interbody fusion, interbody grafting at L5-S1 and L4-5 with interbody fusion and posterior total facetectomy at L5-S1 left and decompressive surgery at L4-5. Because of the total facetectomy, Smith Peterson osteotomy, and resection of the heterotopic bone on the left side, advising that the fusion be run to L4 to S1 for stabilization. It was noted that the procedure needs to be done as soon as possible on an urgent basis because of progressive neurological functional loss. Another note dated 05/13/14 it was an intraoperative monitoring report for the injured worker, Barbara Tisdale for lumbar fusion, revision anterior at L4-5 and L5-S1 decompression, posterior pedicle screw fusion at L4-5 and L5-S1. Monitoring time was 2 hours and 40 minutes. The prior utilization review on 05/14/14 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior revision fusion L4-5, L5-S1 and posterior decompression, pedicle screw fusion:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-308 Surgical Considerations. Decision based on Non-MTUS Citation ODG Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

Decision rationale: The request for anterior revision fusion L4-5, L5-S1 and posterior decompression, pedicle screw fusion is not medically necessary. The imaging studies (CT) of lumbar spine revealed a non-union at L5-S1, no findings of degenerative disc disease or stenosis at the L4-L5 level. Therefore, medical necessity has not been established.

2-3 day inpatient hospital stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, HOSPITAL LENGTH OF STAY.

Decision rationale: The request for 2-3 inpatient stay is predicated on the initial surgical request. As this has not been found to be medically necessary, the subsequent request is not medically necessary.

