

Case Number:	CM14-0192430		
Date Assigned:	11/26/2014	Date of Injury:	05/21/1984
Decision Date:	01/23/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/17/2014

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 Minnesota. 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 an 81-year-old male with a history of discectomy in 1984 and a subsequent posterior lumbar decompression and spinal fusion from L2-S1 performed in 2009 for degenerative scoliosis and back pain. Approximately a year ago he started to develop worsening of his back pain with some radiation to the right buttock. An x-ray report of 9/11/2014 documents 6 lumbar-type vertebral bodies and a posterior fusion from L2 to L6. Multilevel degenerative disc disease and L4-5 spondylolisthesis is noted. There is no loosening of the hardware documented. The report does not indicate a pseudoarthrosis. Prior medical records indicate a long history of low back pain. He was seen on multiple occasions in 2011 and 2012 for back pain. He stated that he developed a foot drop after the spinal fusion. Pain levels were high and he was treated with opioids. On 1/21/2014 he stated that he fell in his garage and had a flare-up of his low back pain. A lumbar CT dated 3/12/14 revealed pedicle screw fixations at L2-L5 with laminectomies and posterior element fusions at multiple levels. There appeared to be loosening of the pedicle screws on the right and left at L2 level. The right L5 pedicle screw appeared to enter the right lateral recess possibly interacting with the right L5 nerve root. There was degenerative disc disease at L1-2 through L6-S1. Documentation indicates history of 2 falls in October and December 2013. Examination on 4/12/2014 revealed that he was out of balance in the coronal plane, slightly to the left. Neurologically there was no motor weakness. Deep tendon reflexes were absent in the lower extremities. Sensation was intact to light touch. There was no rigidity and no clonus. Straight leg raising was negative. An x-ray of the lumbar spine at that time revealed that he was out of balance in the sagittal plane and had broken down the L5-S1 level and there was a left kyphosis there. It was reported that the surgical procedure to correct that would require a significant redo operation which at his age and health status he was not a candidate for. The recommendation was to undergo pain management to control his symptoms

and to make him more ambulatory. A CT of March 2014 showed solid fusions from L2-S1 and grade 1 spondylolisthesis of L5 on L6 and a 3 mm spondylolisthesis of L4 on L5. There was loosening of some of the pedicle screws. There was degenerative disc disease. The CT report suggested screw mobility or loosening at L2 bilaterally at the top of the construct. The disputed issue pertains to a recommendation for an interbody fusion at L2-3 at the top of the long construct. This was noncertified by utilization review for absence of flexion-extension films showing abnormal mobility at L2-3 or the presence of gradually progressive lysis at that level. Furthermore, even in the presence of instability at L2-3, a stand-alone L2-3 anterior construct would not be sufficient and the injured worker was not a good candidate for more extensive surgery. Therefore conservative management was recommended. ODG guidelines were used.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal minimally invasive L2-3 fusion for pseudoarthrosis, lumbar spine with [REDACTED]
[REDACTED]: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

Decision rationale: The documentation indicates a history of chronic low back pain in an 81-year-old injured worker who is status post decompression and fusion from L2-S1. Good sensory and motor function is documented in the lower extremities. A CT scan has revealed radiolucency around the pedicle screws at L2 indicating possible loosening at the top of the fusion construct. The disputed issue is a request for minimally invasive L2-3 fusion in an 81-year-old gentleman with significant health issues. There is a conflicting opinion from his surgeon who thinks that he is out of balance in the sagittal plane and has broken down the L5-S1 level. Any attempt to correct that would be a major procedure for which he was not a candidate. It is not known if there is any instability with flexion/extension at the level of the lucency around the L2 screws. There is no documentation that flexion/extension films were obtained. California MTUS guidelines indicate surgical considerations for severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies with objective signs of neural compromise, activity limitations due to radiating leg pain, or clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. There is no documented evidence of instability at L2 level. Flexion/extension x-rays have not been obtained and definite loosening or instability has not been demonstrated. Even in the presence of instability at this level a limited fusion at L2-3 is not likely to affect the overall clinical picture, that of chronic low back pain and associated disability. The risk of complications with any surgery is significant in an 81-year-old individual with coronary artery disease. There is no clear clinical and imaging evidence of a lesion that has been shown to benefit both in the short-term and long-term from a surgical procedure. Based upon the above the guideline criteria have not been met and the request for a limited minimally

invasive fusion at L2-3 for pseudoarthrosis, lumbar spine is not supported by guidelines and as such is not medically necessary.