

Case Number:	CM15-0133686		
Date Assigned:	07/21/2015	Date of Injury:	09/10/2008
Decision Date:	08/19/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/10/2015

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: Illinois, California, Texas

Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 60-year-old female who sustained an industrial injury on 9/10/08. Past surgical history was positive for anterior cervical discectomy and fusion C4-C7, and posterior lateral fusion from T10-S1 and laminectomy decompression L2-L5 and SI joint arthrodesis in May 2014. The 5/9/14 post-operative CT scan documented interbody fusion hardware in place from L1 to S1, with posterior pedicle screws and rods present from T10-S1. There was no loosening or backing out of hardware present. There was no neural encroachment by the hardware seen. She underwent right L2/3 epidural steroid injection for right thigh pain on 11/4/14. The procedure note indicated that it was technically difficult due to advanced hardware in place and difficulty visualizing the narrowed foramen. Medication was spread at the proper location, but there was poor tracking medially. The injured worker reported 50% relief post procedure. The 5/05/15 treating physician report cited low back pain with pain and weakness in the right anterior thigh. She was using a walker. The injured worker was status post anterior posterior instrumented fusion from L2 through the sacrum. There was intrusion of the L2 interbody graft into the right L2/3 foramen, impinging on the root with radiculopathy. Remediation of the graft intrusion in to the right L2/3 foramen had been long recommended but the injured worker had great concerns about another surgery. However, she now realized that she was not going to improve without relieving the pressure on the nerve. She understood that there may be longstanding neuropathy. The treatment plan recommended revision of the interbody graft with decompression of the right L2/3 foramen. Authorization was requested for revision posterior implant L2-3 with inpatient stay x 1 day and preoperative medical clearance with

Labs/EKG, now under review. The 6/23/15 utilization review non-certified the request for revision of the posterior implant at L2/3 with associated surgical requests as the method of placement of the interbody graft, how well it is fused, and the proposed method of extraction were not detailed to allow determination of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Revise posterior implant L2-3 with inpatient stay x 1 day: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 Lumbar & Thoracic: Fusion (spinal).

Decision rationale: The California MTUS does not provided recommendations for revision lumbar surgeries. 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. Guidelines recommend revision surgery for failed previous fusion at the same disc level if there are ongoing symptoms and functional limitations that have not responded to non-operative care; there is imaging confirmation of pseudoarthrosis and/or hardware breakage/malposition; and significant functional gains are reasonably expected. Guideline criteria have not been met. This injured worker presents with low back and right anterior thigh pain and weakness. She was ambulating with a walker (although there is no documentation that this represents a new onset loss of function). Benefit was noted with a right epidural steroid injection at the L2/3 level. However, there is no orthopedic or neurologic exam documented in the current records. There is no imaging evidence of nerve root compression, pseudoarthrosis, or hardware failure. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Preop medical clearance with Labs/EKG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

