MAXIMUS Federal Services

| Case Number: | CM15-0135494 | | |
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| Date Assigned: | 07/23/2015 | Date of Injury: | 05/14/1998 |
| Decision Date: | 08/31/2015 | UR Denial Date: | 06/09/2015 |
| Priority: | Standard | Application Received: | 07/13/2015 |

## 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 52-year-old male who sustained an industrial injury on 5/14/98. The mechanism of injury was not documented. Past surgical history was positive for lumbar decompression and laminectomies at L4, L5, and S1, medial facetectomies at L5/S1, release of nerve roots bilaterally L4, L5, and S1, non-segmental instrumented arthrodesis L5-S1, and posterolateral arthrodesis on 12/20/11. The 1/31/14 lumbar spine MRI impression documented postsurgical findings of laminectomy with decompression of the central canal at L4/5. There was irregular appearance of the nerve roots at L4/5 and L5/S1, query arachnoiditis. The central canal was decompressed and the neural foramina were patent. There was no significant posterior disc bulge or herniation. At L5/S1, there was anterior interbody graft with no clear anterior solid bony fusion visualized that could be correlated with CT scan. There was interval placement of posterior pedicle screws. There was a postsurgical finding of a laminectomy with decompression of the central canal at this level and the neural foramen were also patent. There was mild thecal sac fibrosis/effacement. The 2/18/14 EMG/NCV of the left lower extremity evidenced likely S1 versus L5 and S1 old, change radiculopathy. The 3/25/15 treating physician report indicated that the injured worker had undergone left sacroiliac joint injection which gave excellent relief temporarily, supporting the left SI joint as an important pain generator. There was significant burning pain reported at the lumbar region over hardware. There was burning pain left foot, 1st dorsal web space, pain down posterior thigh and calf, and cramping and burning pain in calf on the left side. The 4/27/15 treating physician report cited on-going lumbar pain radiating to the posterior thigh to calf and foot on the left side with constant burning in the toes. She was

managing well with medications, including Norco, Lyrica, and Flexeril. Physical exam cited normal gait, tenderness at the lumbosacral junction over pedicle screws on palpation and 50% reduction in range of motion. There was 4/5 weakness noted over the left extensor hallucis longus, posterior tibialis, and gastroc. Deep tendon reflexes were +2 and symmetrical and sensation was intact. Left pelvis/hip exam documented significant tenderness to palpation over the left sacroiliac joint and tenderness on provocative maneuvers, including shear stress test, lateral compression test, FABER and Gaenslen's. Right pelvis/hip exam was within normal limits. X-rays showed sold fusion at L5/S1. The injured worker had radicular pain to the left lower extremity and lumbar post laminectomy syndrome, and tenderness over hardware. Authorization was requested for hardware removal, fusion exploration and decompression to alleviate left radicular pain. EMG showed L5 and S1 radiculopathy. Authorization was requested for removal of hardware L5/S1, fusion exploration and L5/S1 posterior decompression, and one day inpatient stay. The 6/9/15 utilization review non-certified the request for removal of hardware L5/S1, fusion exploration and L5/S1 posterior decompression, and one day inpatient stay as there was no evidence that the injured worker's hardware was responsible for the chronic symptoms reported.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**1 removal of Hardware Lumbar L5-S1, Fusion Exploration L5-S1 Posterior Decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back & Lumbar & Thoracic (Acute & Chronic), Hardware implant removal (fixation); hardware injection (block).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar & Thoracic: Discectomy/Laminectomy; Hardware injection (block); Hardware implant removal (fixation).

**Decision rationale:** The California MTUS does not provide recommendations relative to lumbar hardware removal. The Official Disability Guidelines do not recommend the routine removal of hardware implanted for fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Guidelines recommend the use of a hardware injection (block) for diagnostic evaluation in patients who have undergone a fusion with hardware to determine if continued pain was caused by the hardware. If the steroid/anesthetic medication can eliminate the pain by reducing the swelling and inflammation near the hardware, the surgeon may decide to remove the patient's hardware. The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians

consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guideline criteria have not been fully met. This injured worker presents with low back pain radiating down the left lower extremity to the foot with constant burning pain in the toes. Clinical exam, imaging, and electrodiagnostic findings are consistent with L5 and S1 radiculopathy. Clinical exam and diagnostic injection response additionally suggest the left sacroiliac joint as a pain generator. Evidence of a reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is radiographic evidence of fusion at the L5/S1 level. However, there is no evidence of a diagnostic hardware injection to support hardware as a pain generator or radiographic findings of hardware failure. Therefore, this request is not medically necessary at this time.

**Associated surgical service: One Day Inpatient Stay:** 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.