

Case Number:	CM15-0216974		
Date Assigned:	11/06/2015	Date of Injury:	01/04/2002
Decision Date:	12/29/2015	UR Denial Date:	10/22/2015
Priority:	Standard	Application Received:	11/04/2015

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: Minnesota, Florida
 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:

The injured worker is a 54-year-old male with a date of injury of 1/4/2002. Documentation indicates a pain disorder associated with psychological factors and chronic orthopedic conditions. The orthopedic issues include status post C4-5, C5-6, C6-7 discectomy and fusion (6/29/1998), right open carpal tunnel release (March 2000), 3 level BAK surgery L2-3, L3-4, and L4-5 (01/01), cervical fusion (07/02), and status post exploration of lumbar fusion replacement of hardware, L2-3, L3-4, and L4-5 (02/03), status post anterior lumbar interbody fusion and discectomy at L5-S1 (03/03). Documentation from 7/6/2015 indicates chronic back pain, failed back syndrome of lumbar spine, spinal stenosis, hypertension, and tooth infection. A Neurosurgical visit of July 2015 documents cervical spinal fusion in 2000, redone in 2002, fusion of lumbar spine in 1998, redone in 2002, fracture surgery of the cervical spine with 3 areas haven't been fused and multiple fractures in the lower back with lumbar fusion in multiple areas. In January 2015 there was removal of medication infusion pump. He was on multiple opioid medications area he was a current every day smoker for 30 years. On examination, stance and gait were abnormal; there was a stooped posture with legs flexed. He was able to toe, heel, and tandem walk. Range of motion of the lumbar spine was decreased. There was no spasm or tenderness. Motor strength was 5/5 in all extremities and reflexes were 2+ and symmetric throughout. Sensory examination did not reveal any dermatomal deficits. MRI of the lumbar spine showed previous fusion from L2-S1. There was degenerative disc disease at T12/L1 and L1/2 that caused mild-to-moderate canal stenosis. On the sagittal T2 view there appeared to be some abnormal signal focal within the cord at T12/L1 although this was present on only one

slice. The provider suggested additional diagnostic workup with flexion/extension films and upright scoliosis views to understand his global balance. A CT of the lumbar spine dated 7/22/2015 revealed extensive postsurgical changes from L2 through the sacrum. There was advanced degenerative disc disease at T12-L1 and L1-L2 with moderate spinal stenosis and a component of bilateral neural foraminal narrowing. The fusion mass was solid from L2 to pelvis. The standing scoliosis x-rays demonstrated sagittal deformity with S VA greater than 120 mm (normal less than 5 mm), PI-LL mismatch greater than 20° (normal plus/-9°). The documentation from 10/8/2015 indicates presence of a sagittal plane lumbar deformity. Surgery had been discussed and he was trying to cut down on his smoking. He had been off smoking for about 10 days. The provider diagnosed neurogenic claudication and sagittal deformity with back pain. The procedure suggested was T9 pelvis posterior instrumented fusion with L3 pedicle subtraction osteotomy and T12-L1, L1-2 laminectomy for deformity correction and decompression. The procedure was noncertified by utilization review as guidelines did not support a fusion for sagittal deformity. Furthermore, there was no documentation of physical medicine and manual therapy, evidence of instability or nerve impingement necessitating surgery, the fusion was at greater than 2 levels and there had been no psychosocial screen. Also, there was no documentation of having stopped smoking for 6 weeks. The request for fusion on the basis of a sagittal imbalance was not supported by guidelines. ODG was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Removal of previous instrumentation; T9-pelvis instrumentation with LS pedicle subtraction osteotomy: 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), Low Back, Fusion (spinal).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation ODG: Section: Low back, Topic: Fusion.

Decision rationale: This is a complex issue with chronic back pain, status post multiple fusion procedures, and a request for T9-pelvis posterior instrumented fusion with L3 pedicle subtraction osteotomy and T12-L1, L1-2 laminectomy for deformity correction and decompression of a sagittal imbalance type deformity in a chronic smoker who is attempting smoking cessation for the procedure. And there is no instability documented. California MTUS guidelines do not address this complex issue but also do not recommend a fusion in the absence of documented instability. ODG guidelines recommend all physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts, x-rays demonstrating spinal instability and/or myelogram, CT myelogram or MRI demonstrating nerve root impingement correlated with symptoms and examination findings, spinal fusion to be performed at 1 or 2 levels, psychosocial screen with confounding issues addressed, it is recommended that the injured worker refrain from smoking for at least 6 weeks, and also during the period of fusion healing. In this case, the documentation indicates physical medicine and

manual therapy interventions have not been completed, there is no instability on the x-rays or other imaging studies, evidence of nerve root impingement is not documented, the spinal fusion is being performed at more than 2 levels, and psychosocial screen is not documented. Furthermore, the injured worker is trying to stop smoking but has not refrained from smoking for at least 6 weeks. As such, the request for surgery is not supported and the medical necessity of the request has not been substantiated.

Associated surgical service: Assistant surgeon: 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), Low Back, Fusion (spinal).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

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

Associated surgical service: Inpatient times 7 days: 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), Low Back, Fusion (spinal).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

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