

Case Number:	CM15-0057885		
Date Assigned:	04/02/2015	Date of Injury:	11/09/2001
Decision Date:	05/15/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/26/2015

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 67 year old male, who sustained an industrial injury on 11/09/2001. The initial complaints and diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, conservative therapies, x-rays, MRIs, CT scans, psychological therapy, microdiscectomy of the lumbar spine (03/2002), laminectomy (04/2002), lumbar L4-S1 fusion surgery (08/08/2002) with hardware removal (06/05/2003), lumbar L3-L4 fusion surgery (03/25/2014), external bone stimulation, electrodiagnostic testing, and intrathecal pain pump placement. Currently, the injured worker complains of ongoing low back pain described as "arachnoiditis pain" with radiation to both lower extremities. The diagnoses include status post lumbar fusion surgery to the L3-4 (03/25/2014), chronic low back pain, status post lumbar microdiscectomy, status post lumbar laminectomy, status post lumbar fusion at L4-S1, and status post lumbar hardware removal. The treatment plan consisted of L3-L4 hardware removal with exploration of fusion with possible revision of fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-4 removal of hardware,exploration of fusion, with possible revision fusion: 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), Hardware implant removal.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Low Back, Topic: Hardware removal, Fusion, revision of fusion.

Decision rationale: On 12/2/2014, the injured worker presented himself for follow-up on low back complaints and bilateral lower extremity symptoms. He had undergone a spinal fusion with TLIF on 3/25/2014 at the L3-4 level. He stated that he continued to see significant improvement since the surgery. The pain from the "pinched nerve" was 100% resolved. However, he continued to have "arachnoiditis pain". He also reported an injury when he was up on a ladder and he fell landing on his back. His pain level was 7-8/10. The pain was present in bilateral lower extremities and was worse with prolonged standing. On examination, his gait was normal. Range of motion of the lumbar spine was decreased. He was tender to palpation in the lumbar mid spine. An x-ray of the lumbar spine dated 12/2/2014 revealed an L3 compression fracture. The L3 screw was violating the L2-3 disc space. A prior CT scan dated 3/18/2014 revealed an old mild L3 compression fracture. The degree of compression with the new films is not reported. His CT scan of the lumbar spine was advised and treatment options including hardware removal with exploration of the fusion and subsequent conservative treatment with bracing was discussed. A TLSO brace was prescribed. EMG and nerve conduction studies were requested. The electrodiagnostic studies revealed evidence of a left L3/4 radiculopathy, and right S1 radiculopathy. The CT scan of the lumbar spine dated 1/14/2015 was reported to show no recurrent herniation, canal or foraminal stenosis at L4-5 and L5-S1. There was mild bilateral foraminal stenosis with no central canal stenosis at L3-4. There was a disc protrusion and facet hypertrophy at L2-3 resulting in mild-to-moderate canal, moderate left and mild to moderate right sided foraminal stenosis. There was mild to moderate canal and bilateral foraminal stenosis at L1-2. There appeared to be an old compression deformity involving the L3 vertebral body with 20-30% compression. There was a catheter entering the thecal sac at L1-2, the tip of the catheter was behind T12. There was a second catheter entering the spine at T11. The CT scan as reported indicates an old compression deformity of L3 with 20-30% compression. Prior documentation also indicated this deformity although the degree of compression was not reported. There was no problem with the hardware reported. In particular, there was no compression of any neural structures by the hardware. Failed low back surgery and placement of an intrathecal pain pump has been documented. In light of the absence of any hardware related complications or hardware failure, removal of hardware is not supported by guidelines. ODG guidelines recommend hardware removal in the case of broken hardware or persistent pain after ruling out other causes of pain such as infection and nonunion. A hardware injection block is recommended only for diagnostic evaluation of field back surgery syndrome. ODG guidelines indicate that revision surgery for spinal fusion should be approached with extreme caution. As such, in light of the foregoing, the request for L3-4 hardware removal and revision of the fusion is not medically necessary.