

<b>Case Number:</b>	CM15-0086142		
<b>Date Assigned:</b>	05/08/2015	<b>Date of Injury:</b>	09/04/2008
<b>Decision Date:</b>	06/09/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2015

### 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:

The injured worker is a 60-year-old male who sustained an industrial injury on 9/04/08. Past surgical history was positive for posterior lumbar transforaminal arthrodesis at L3/4 on 3/2/10, revision posterior fusion L3/4 and L3-S1 decompression with interspinous device on 8/8/13, anterior cervical discectomy and fusion at C5-7 on 2/5/14, and posterior spinal fusion at L4-S1 with pedicle screw fixation, bilateral revision laminectomies at L4-S1, and bilateral Gill laminectomy at L4/5 and L5/S1 with extensive neurolysis and nerve decompression on 6/10/14. He underwent primary repair of durotomy and spinal fluid leakage and placement of a lumbar drain with use of inter-wound platelet-rich plasma on 6/25/14. Post-surgical treatment included spinal bone growth stimulator and physical therapy. The 1/5/15 lower extremity electro-diagnostic study findings were consistent with active bilateral L5/S1 radiculopathy. The 1/26/15 lumbar spine MRI impression documented a new fusion from L3 through S1 with pedicle screws and posterior fusion bars. There was extensive metallic artifact distorting the lower lumbar spine. The nerve roots appeared irregularly clumped posteriorly to the right of midline and arachnoiditis in the distal thecal sac could not be excluded. There was a large oval fluid collection posterior to the thecal sac from L3/4 to L5/S1 which may represent a post-operative seroma. There was left foraminal narrowing at L3/4, possible right foraminal narrowing at L4/5, and probable bilateral foraminal narrowing at L5/S1. There was some residual osteophyte at L3/4. At L5/S1, there was a 4-5 mm disc bulge or granulation tissue, and a gadolinium-enhanced study was recommended for differentiation. The 3/10/15 lumbar CT scan impression documented a limited study due to L3 through S1 fusion hardware. There were

lucencies surrounding the screw tips in the sacrum and comparison with prior post-operative films was recommended. There was very little bone graft material posteriorly without definite incorporation. There was still a large fluid collection posterior to the thecal sac over the operative segments. There appeared to be either residual disc material or granulation tissue at L5/S1 with foraminal narrowing at this level. The 3/17/15 treating physician report cited constant severe mechanical axial back pain radiating into the left leg and down to the toes with numbness. Physical exam documented continued significant dysfunction in the bilateral L5 and S1 motor distributions and light touch distributions. CT scan was reviewed and showed a pseudoarthrosis, failed fusion at the L4/5 and L5/S1 levels with bilateral foraminal stenosis from bone spur formation. The diagnosis was pseudoarthrosis L4/5 and L5/S1 with significant and severe mechanical back pain and leg radiculopathies due to pseudoarthrosis and bone spur formation. The treating physician opined that no therapies or injections would improve the injured worker's symptoms and he absolutely required a revision surgery. Authorization was requested for pre-sacral lumbar interbody fusion L4-S1 as a revision fusion, posterior spinal revision including removal of instrumentation and replacement with larger screws, removal of bony hyperostosis at bilateral L4/5 and L5/S1 levels. Authorization was also requested for a lumbar spine MRI to include the coccyx prior to surgery. The 4/9/15 utilization review non-certified the request as there was recent imaging evidence of a large fluid collection posterior to the thecal sac on the operated segments which could be indicative of an infection and arachnoiditis could not be ruled out, and there was no evidence that there had been an attempt to rule-out infection. Additionally, there was no documentation of failure of any recent conservative care.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Revision presacral interbody fusion L4-S1, posterior spinal revision involving removal of instrumentation and replacement with larger screws, removal of bony hyperostosis at bilateral L4-5, L5-S1 levels:** Overturned

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

**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 provide recommendations for revision lumbar fusion surgery. The Official Disability Guidelines (ODG) recommend 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. Spinal fusion is additionally recommended for infection that causes intractable pain. Guideline criteria have been met. This injured worker presents with constant severe mechanical back pain radiating into the left lower extremity. Signs/symptoms and clinical exam findings are consistent with electrodiagnostic evidence of L5 and S1 radiculopathy. There is imaging evidence of pseudoarthrosis at L4/5 and L5/S1. Overall, there does not appear to be evidence of infection nor acachnoiditis. Detailed evidence of a

reasonable and/or comprehensive conservative treatment protocol trial, including physical therapy and bone growth stimulator, and failure has been submitted. Therefore, this request is medically necessary.

**Inpatient hospitalization x 3 days: Overturned**

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

**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: Hospital length of stay (LOS).

**Decision rationale:** The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for posterior lumbar fusion is 3 days. This request for a 3-day inpatient stay is consistent with guidelines. Therefore, this request is medically necessary.

**Associated surgical service - MRI lumbar spine to include coccyx: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic: MRIs (magnetic resonance imaging).

**Decision rationale:** The California MTUS guidelines state that unequivocal objective findings of specific nerve compromise on the neurologic exam are sufficient to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. Guidelines do not address repeat or pre-surgical MRIs. The Official Disability Guidelines state the repeat MRI s not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neuro-compression, and recurrent disc herniation). Guideline criteria have not been met. A lumbar spine MRI was performed on 1/26/15, and a CT scan was performed 3/27/15. There is no evidence of a change in symptoms and/or findings to support repeat imaging. There is no compelling rationale presented to support the medical necessity of coccygeal imaging prior to surgery. Therefore, this request is not medically necessary.