MAXIMUS Federal Services

Case Number:	CM15-0087798		
Date Assigned:	05/12/2015	Date of Injury:	09/14/1995
Decision Date:	06/11/2015	UR Denial Date:	04/25/2015
Priority:	Standard	Application Received:	05/07/2015

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 62-year-old female who sustained an industrial injury on 9/14/95. The mechanism of injury was not documented. Past medical history was positive for chronic obstructive pulmonary disease, cerebrovascular accident, deep vein thrombosis, diabetes mellitus type 1, and anxiety and depression. Past surgical history included removal of hardware at L4/5, Smith-Peterson osteotomy at T12-L4, decompression at L2-4, posterior spinal fusion at T3-Pelvis, and bilateral iliac fixation on 2/23/12, revision of T3-P with decompression with osteotomies at T11, T12, L4, and L5 possibly vertebral column resection on 10/19/12, and removal of instrumentation and posterior spinal fusion at T1-7 on 7/24/14, and irrigation and debridement of epidural abscess on 8/12/14. The 2/10/15 scoliosis study noted anterior sagittal imbalance of 4.7cm and coronal imbalance of 12.7 cm. There was multilevel cervical spine degenerative disc disease with multilevel disc narrowing and anterior osteophytes, and mild anterolisthesis of C3 on C4. There was posterior fixation with bipedicular screws and rods and sub laminar wires extending from T3-S1 with bilateral iliac bolts. There was minimal lucency about the right S1 pedicular screw as before with no new evidence of hardware complication. There was mild wedging of the T7 vertebral body as before, mild degenerative changes of the bilateral hips, and diffuse osteopenia. The 2/10/15 treating physician report cited complaints of grade 7/10 neck pain, grade 4/10 right arm symptoms related to the neck, grade 7/10 back pain, grade 1/10 left leg and grade 6/10 leg symptoms related to the mid to low back, and difficulty walking. She was still being following by infectious disease and was taking Minocycline. She reported an onset of significant anterolateral leg pain over the past 2 weeks. She reported that

over the past 1½ months, her posture had been declining and she was now leaning over to the right. She used a cane at home and wheelchair for outside the home. Pain was aggravated by standing, walking, and bending. Medications were reported 70% effective, and physical therapy 50% effective. Oswestry score was 83%. Review of systems documented frequent headaches, lightheadedness trying to stand, heart palpitations, cough, and shortness of breath. Physical exam documented 5/5 lower extremity strength bilaterally but for iliopsoas strength which was 4/5 bilaterally. Bilateral lower extremity sensation was within normal limits. Bilateral upper and lower extremity deep tendon reflexes were +1 and symmetrical throughout. Straight leg raise was positive bilaterally. The diagnosis was coronal plane deformity. She remained wheelchair bound due to coronal imbalance. Surgery was requested to include revision posterior spinal fusion T3- ilium with asymmetrical osteotomy at L3. The 3/6/15 pain management report cited horrible neck pain. She had already had cervical to lumbar fusion and instrumentation and was scheduled for another cervical surgery. Medications were working somewhat to decrease pain. She also had back pain. Pain was reported 8/10 without medications and 7/10 with medications. Current medications included Lidoderm patches, Morphine sulfate IR, Effexor, MSContin, and Zanaflex. Physical exam documented decreased cervical and lumbar range of motion, full upper and lower extremity strength, and lumbar spinal and facet joint tenderness. The diagnosis included lumbago, low back pain, cervical pain, cervicalgia, myofascial pain syndrome, fibromyalgia, and long-term prescription medication use. An injection of Toradol was provided. The 4/25/15 utilization review non-certified the request for posterior spinal fusion, T3 to ilium, instrumentation, S1 screw, osteotomy, and graft based on failure to meet guidelines criteria and the risks outweighed the potential benefits in this injured worker who had 4 previous surgeries, osteopenia, and previous spine infection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Posterior Spinal Fusion, (Thoracic to Illium) T3 To Illium, Instrumentation, S1 Screw, Osteotomy & Graft: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-194.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic: Fusion (spinal); Fusion for adult idiopathic scoliosis.

Decision rationale: The California MTUS guidelines state there was no good evidence that spinal fusion alone was effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there was instability and motion in the segment operated on. The Official Disability Guidelines (ODG) state that spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. Fusion is recommended for adult idiopathic scoliosis when significant deformity is present. Criteria include 3 months of non-surgical care (education, exercises, and anti-inflammatory medications), curvatures over 50 degrees with persistent pain in adults, progressive mid and low back curve or low back curve with persistent pain, reduced heart and lung function, and adults under 50 years old due to surgical risks, but exceptions are possible. Fusion is recommended for objectively demonstrable segmental instability, such as excessive motion with degenerative spondylolisthesis, or for deformity of the lumbosacral spine

that causes intractable pain, neurologic deficit, and/or functional disability. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability, spine pathology limited to 2 levels, and psychosocial screening with confounding issues addressed. Guideline criteria have not been met. This injured worker presents with significant radicular back pain with severe functional disability. She is status post cervical to ilium fusion with additional cervical surgery reported as imminently pending. There is no radiographic evidence of spinal segmental instability at any thoracolumbar level. There is radiographic evidence of lucency about the pedicular screw at S1 and diffuse osteopenia. The current coronal imbalance is documented as 12.7cm. There is lung dysfunction noted but the injured worker has an underlying history of chronic obstructive pulmonary disease. There is no evidence of a psychosocial screen or psychological clearance for this surgery. This patient exceeds the age criteria for scoliosis surgery with significant co-morbidities (prior cerebrovascular accident, diabetes mellitus type 1, and osteopenia) and prior post-operative issues including deep vein thrombosis and spinal infection. There is no rationale presented to support an exception to guidelines relative to age. Therefore, this request is not medically necessary.