

Case Number:	CM14-0149294		
Date Assigned:	09/19/2014	Date of Injury:	04/04/1994
Decision Date:	11/13/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/15/2014

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. The expert reviewer is Board Certified in Orthopedic Spine Surgeon and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 50-year-old female who reported injury on 04/04/1994. The mechanism of injury was not provided. The medications and other therapies were not provided. The injured worker had a lumbar fusion 18 years prior to the request. The documentation indicated the injured worker had undergone numerous back surgeries and lost weight following bariatric surgery. The injured worker had a spinal cord stimulator. The injured worker underwent a CT post myelogram on 07/21/2014 which revealed at L4-5, there was a small diffuse disc bulge that was slightly asymmetric small 2 to 3 mm bilateral foraminal components and mild facet arthropathy with mild to moderate bilateral neural foraminal stenosis. There was no significant bony spinal canal stenosis at L4-5. At L5-S1, there was a small approximately 3 to 4 mm foraminal disc osteophyte complex resulting in moderate right sided neural foraminal stenosis likely encroaching upon the exiting right L5 nerve root. There was mild left foraminal endplate spurring with mild left sided left neural foraminal stenosis. There was no significant bony spinal canal stenosis. There was a small defect within the posterior left iliac bone likely the site of the prior fusion donor site. There was an addendum on the 07/21/2014 report, which revealed the prior instrumentation at L5-S1 had mild lucency along the posterior margins of the L5 pedicle screw. The right L5 pedicle screw medially extended along the medial margin of the right L5 pedicle adjacent to the right lateral recess just lateral to the inferiorly traversing right S1 nerve root. The documentation of 08/13/2014 indicated the radiologist had an addendum report which revealed right sided L5 pedicle screw along the medial part of the pedicle that was irritating the nerve. The injured worker had a positive straight leg raise on physical exam on the right. The injured worker had slight weakness of the left leg consistent with RSD. The ankle dorsi and plantar flexor strength was 5/5 and the quadriceps and iliopsoas strength was 5/5. Diagnoses included bilateral foraminal stenosis, status post decompression and fusion at L5-S1 and right L5

pedicle screw cut out in. The treatment plan included a removal of hardware, exploration of the fusion mass, and possible augmentation followed by decompression of the right L5 nerve root, additionally, the injured worker had a percutaneous spinal cord stimulator electrode though the battery had been removed to allow for an MRI and the request was made for electrodes to be removed. Additionally, a request was made for pain management. There was no Request for Authorization submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Removal of hardware lumbar spine, exploration of fusion mass, possible augmentation followed by decompression of the right L5 nerve root: 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): 305-307. Decision based on Non-MTUS Citation Guidelines (ODG) Low Back Chapter, Hardware Implant Removal, Hardware injection (block)

Decision rationale: The Official Disability Guidelines (ODG) does not recommend routine hardware removal except in the case of broken hardware or persistent pain after ruling out other causes of pain, such as infection and nonunion. The clinical documentation submitted for review failed to indicate the injured worker had broken hardware. Additionally, hardware injections are recommended for diagnostic evaluation of failed back surgery syndrome. There was a lack of documentation indicating the injured worker had undergone a diagnostic hardware injection. The clinical documentation submitted for review failed to indicate the injured worker had electrodiagnostic findings to support the necessity for decompression of the right L5 nerve root. Given the above, the request for removal of hardware lumbar spine, exploration of fusion mass, possible augmentation followed by decompression of the right L5 nerve root is not medically necessary.

Removal of electrodes lumbar spine from spinal cord stimulator implant: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Treatment Guidelines Spinal cord stimulators.

Decision rationale: The California MTUS Guidelines recommend spinal cord stimulators for injured workers in cases when less invasive procedures have failed or are contraindicated. The clinical documentation submitted for review indicated the injured worker had the battery of the spinal cord stimulator removed. The clinical documentation indicated the rationale for the removal of the electrodes was to allow for a future MRI. However, there was a lack of documentation indicating that the electrodes had failed or were causing irritation. Given the

above, the request for removal of electrodes lumbar spine from spinal cord stimulator implant is not medically necessary.

4 day inpatient hospital 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: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.