MAXIMUS Federal Services

Case Number:	CM14-0213474		
Date Assigned:	12/30/2014	Date of Injury:	10/06/2009
Decision Date:	02/27/2015	UR Denial Date:	11/22/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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: 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 36-year-old female who reported an injury on 10/06/2009. The mechanism of injury was the injured worker was carrying a box of grapes when she stumbled. The injured worker underwent an epidural steroid injections with temporary benefit. The injured worker underwent a transforaminal lumbar interbody fusion at L4-5 and L5-S1, along with pedicle screw fixation on 10/12/2012. The documentation of 11/03/2014 revealed the injured worker was in the office for a followup and re-evaluation of continued, chronic, residual, and persistent postoperative pain. The injured worker was noted to be treated with postoperative physical therapy, pharmacological treatment, and activity modification, as well as observation. The injured worker was inquiring whether she could have elective definitive removal of the retained hardware. The physical examination revealed the injured worker had tenderness to palpation at the surgical site. The straight leg raise was mildly positive for back pain. The injured worker had no motor or sensory deficits. No new plain radiographs were taken. The diagnosis included painful retained lumbar hardware following transforaminal lumbar interbody fusion. The request was made for surgical intervention. The injured worker underwent a CT of the lumbar spine without contrast on 06/24/2014 which revealed at L4-5, there were postsurgical changes. The soft tissue details of the spinal canal in both neural foramina were degraded by metal artifacts from the posterior stabilization instrumentation. There was no appreciable significant stenosis. At L5-S1, there were postsurgical changes. The soft tissue details of the spinal canal in both neural foramina were degraded by metal artifacts from the posterior stabilization instrumentation. There was no appreciable significant stenosis. There was a slight

retrolisthesis of L5 on S1 without spondylosis. Other therapies were noted to include physical therapy and chiropractic treatment. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Exploration of Lumbar Spine With Removal of Lumbar Hardware: 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, Lumbar & Thoracic (Acute & Chronic)

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 Chapter, Hardware implant removal (fixation).

Decision rationale: The Official Disability Guidelines indicate that routine removal of hardware implanted for fixation except of the cases of broken hardware and persistent pain after ruling out other causes of pain, such as infection or nonunion, is inappropriate. The clinical documentation submitted for review failed to provide documentation that other causes of pain had been ruled out, such as infection and nonunion. There was no documentation of broken hardware. The request as submitted failed to indicate what, specifically, "exploration of the lumbar spine" included. The request as submitted failed to indicate the level for the requested surgical intervention. Given the above, the request for Exploration of Lumbar Spine With Removal of lumbar hardware is not medically necessary.