

Case Number:	CM15-0010917		
Date Assigned:	01/28/2015	Date of Injury:	05/05/1994
Decision Date:	03/18/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/20/2015

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:

This 63 year old female sustained a work related injury on 05/05/1994. The injury occurred when she was sitting in a chair and the chair leg broke, causing her to fall backwards landing on the chair. She underwent multiple subsequent lumbosacral spine surgeries, including interbody fusion L2-L5, posterior fusion T10-L2, L5/S1 transforaminal lumbar interbody fusion (TLIF) on 1/31/13, and removal of hardware. She continued to have severe pain. Past medical history was notable for obesity, hypertension, depression, and anxiety. The 11/27/13 lumbar CT scan findings documented the new L5/S1 interbody fusion graft was not well incorporated. Hardware was intact. There was diffuse bony demineralization. Small ventral osteophytes were seen at all lumbar levels. There was no significant spinal canal stenosis or neuroforaminal narrowing. The 11/27/13 lumbar MRI documented multilevel degenerative changes, worst at L5/S1 with moderate central spinal canal stenosis and moderate to severe mass effect on the bilateral traversing S1 nerve roots. The 10/22/14 lumbar spine x-rays showed stable TLIF post-op changes and discectomy with interbody graft at L3/4 and L5/S1 with no evidence of hardware failure. There was diffuse mineralization with mild dextrocurvature of the thoracolumbar spine centered at L2. There was no evidence of acute compression fracture, significant spondylosis, or spondylolisthesis. The 12/1/14 scoliosis study impression documented stable degenerative changes at L2/3 characterized by disc space narrowing, mild retrolisthesis, and prominent osteophytosis. The 10/22/14 treating physician appeal report cited severe back pain in the mid and lower back with notable spasms. Physical exam documented antalgic gait, difficulty with heel and toe walk, and inability to tandem walk. She was able to heel and toe raise with no

significant myelopathy noted. There was tenderness from T12 into the lumbar spinal processes, minimal paraspinous tenderness, and moderate to marked loss of lumbar range of motion. Hip flexor strength was 3/5 right, 4/5 left. Hip abductors were 4+/5 bilaterally. Other lower extremity muscle groups were 5/5 bilaterally. Right patellar reflex was diminished to 1+. She had one beat clonus. Straight leg raise was positive bilaterally. The treating physician stated that the patient had a pseudoarthrosis and incomplete fusion at L5/S1 with notable spinal stenosis and nerve compression documented in the CT scan and MRI reports. She had significant lumbar kyphotic deformity measuring approximately 25 degrees. Overall, she had a 10 cm positive sagittal balance where she was completely forward leaning and unstable with decompensated kyphosis. These factors were incompatible with normal gait and caused severe pain and radiculitis. She needed an L3 pedicle subtraction osteotomy and a revision T10-S1 and ilium spinal fusion with instrumentation. According to the pain management report dated 12/02/2014, the injured worker continued to have severe back and left leg pain and spasms, and felt that something was locked. On 01/15/2015, Utilization Review non-certified lumbar spine fusion based on no demonstrated segmental instability, multilevel spinal pathology, and no psychosocial screen. The Official Disability Guidelines, for Low Back Fusion was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3 pedicle subtraction osteotomy and revision T10-S1 and ilium spinal fusion with instrumentation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Fusion (spinal)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back "Lumbar & Thoracic: Spinal (fusion) Wheelless" Textbook of Orthopaedics. Post-Traumatic/Post Surgical Kyphosis. http://www.wheelsonline.com/ortho/post_traumatic_post_surgical_kyphosis Kyphosis <http://www.wheelsonline.com/ortho/kyphosis> Updated 4/13/12.

Decision rationale: The California MTUS ACOEM guidelines do not address revision lumbar fusion. 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. 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. The Wheelless Textbook of Orthopedics generally recommend fusion with possible osteotomies for correction of postsurgical kyphosis. In general, conservative treatment of kyphosis is recommended for curves less than 50 degrees. Guideline and peer-reviewed criteria have not been fully met. There are imaging findings consistent with a pseudoarthrosis at L5/S1 with no evidence of hardware failure. There is no current radiographic evidence of spinal segmental instability. The current thoracolumbar kyphosis is documented at approximately 25

degrees, which does not support the medical necessity of osteotomy and long-construct revision fusion at this time, as per references. A psychosocial evaluation is not evidenced. There is no detailed evidence of recent comprehensive conservative treatment beyond medications and activity modification. Therefore, this request for L3 pedicle subtraction osteotomy and revision T10-S1 and ilium fusion with instrumentation is not medically necessary at this time.

3 day inpatient 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.