

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0062428 | | |
| Date Assigned: | 04/08/2015 | Date of Injury: | 02/01/1996 |
| Decision Date: | 05/19/2015 | UR Denial Date: | 03/10/2015 |
| Priority: | Standard | Application Received: | 04/01/2015 |

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 65-year-old male who sustained an industrial injury on 2/01/96. The mechanism of injury was not documented. Past surgical history was positive for L4-S1 discectomy and fusion with posterior instrumentation of L4 and S1 with disc spacers present at L4/5 and L5/S1 and interbody bony fusion at L4/5. The 9/12/14 lumbar spine MRI impression documented small central disc extrusion at L2/3 extending cephalad to this level but no significant central canal or neuroforaminal narrowing and no adjacent segment disease at L3/4. Post-surgical changes were noted at the L4/5 and L5/S1 with no discussion of hardware failure. The 10/30/14 treating physician report documented point tenderness over the hardware in his lumbar spine. He had a thin frame without much fat in the lower lumbar spine. His hardware is superficial and tenderness was localized to that hardware. Removal of the hardware is probably going to be indicated but the operating surgeon had recommended diagnostic hardware injections. The hardware injections were denied in utilization review and were appealed. The 12/09/14 treating physician report cited a flare up of lumbar muscle spasms and discomfort lifting the back gate of his truck. His hardware diagnostic injections have been denied. At this point, he was going to return to the surgeon and likely simply have those screws pulled out. He had significant muscle spasms and lower lumbar tenderness above his fusion. He was taking ibuprofen and prescribed Flexeril and Norco. The plan of care included medications and possible surgical intervention and authorization was requested for consultation with an orthopedic surgeon and hardware removal of the lumbar spine. The 3/10/15 utilization review non-certified the request for consult for an orthopaedic surgeon for the lumbar spine as the primary treating

physician was an orthopaedic surgeon and there was no clear rationale to establish the medical necessity of consultation with a different orthopaedic surgeon. The request for lumbar spine hardware removal surgery was non-certified as there was no evidence of broken hardware, infection or non-union, or documentation of positive diagnostic hardware injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consultation with orthopedic surgery lumbar spine: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127.

Decision rationale: The California MTUS guidelines provide general recommendations for referral to orthopedic surgeons for the lumbar spine but do not address for follow-up visit. The ACOEM guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Guideline criteria have been met. This patient presents with on-going localized pain over the lumbar spine hardware. Evaluation with another operating surgeon is reasonable to assess the current hardware status. Therefore, this request is medically necessary.

Hardware Removal Surgery Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Low Back Procedures Summary.

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, Hardware implant removal (fixation); Hardware injection (block).

Decision rationale: The California MTUS does not provide recommendations relative to lumbar hardware removal. The Official Disability Guidelines do not recommend the routine removal of hardware implanted for fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Hardware removal is not recommended solely to protect against allergy, carcinogenesis, or metal detection. Although hardware removal is commonly done, it should not be considered a routine procedure. Guidelines recommend the use of a hardware injection (block) for diagnostic evaluation in patients who have undergone a fusion with hardware to determine if continued pain was caused by the hardware. If the steroid/anesthetic medication can eliminate the pain by reducing the swelling and inflammation near the hardware, the surgeon may decide to remove the patient's hardware. Guideline criteria have not been met for hardware removal at this time. The patient

presents with persistent lumbar spine pain over the area of the lumbar hardware. He has a thin build and hardware is palpable. A diagnostic hardware injection has not yet been completed to confirm that pain complaints are generated at the hardware site. Therefore, this request is not medically necessary at this time.