

Case Number:	CM15-0094797		
Date Assigned:	05/20/2015	Date of Injury:	06/18/2012
Decision Date:	06/24/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	05/15/2015

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 injured worker is a 43-year-old male who sustained an industrial injury on 6/18/12. The mechanism of injury was not documented. He underwent L5/S1 discectomy and fusion on 1/9/15. Subsequent to the surgery, he reportedly fell at home in February with acute onset of severe pain. The 3/6/15 lumbar CT scan documented interval post-surgical changes with vertebral body fusion L5/S1. Surgical hardware was intact. At L5/S1, there was no obvious disc bulge or herniation. There was mild left-sided neuroforaminal stenosis. Findings documented bilateral transpedicular screws were intact with no lucency surrounding the hardware to suggest loosening or infection. There was no hardware fracture seen. Interdisc space material was seen at L5/S1 facilitating bone fusion. The 4/16/15 treating physician report cited continuous severe pain following the February fall. He sustained two recent falls and was reporting increased low back pain with some right leg radiation since. He was very heavy and the concern was that he had broken the hardware. Physical exam documented no apparent motor or sensory deficits. The CT scan showed the left rod might have moved when he fell resulting in the instrumentation not providing sufficient stabilization. There was no sign of broken hardware and the canal was wide open with no compromise of the nerve roots. The diagnosis was status post L5/S1 transforaminal discectomy and fusion on 1/6/15 with two falls since surgery and hardware malalignment. The treatment plan recommended re-exploration of the surgery site and hardware repositioning. The 5/8/15 utilization review non-certified the request for L5/S1 re-exploration and hardware replacement and associated physical therapy as there was no documentation of x-ray findings showing malposition of the pedicle screws or signs of loosening or breaking of the hardware so

support the medical necessity of surgery. The 5/14/15 treating physician appeal letter stated that he had personally reviewed the 3/6/15 lumbar CT scan and could clearly see abnormality in the post-surgical hardware position. The radiologist had been contacted and had issued a supplemental report regarding the 3/6/15 lumbar CT scan. He was not solely concerned with the sudden increase in severe low back pain and clicking sounds coming from his back since the fall, but that he was going to have a failed fusion. The patient had fallen and landed on his knees on several occasions subsequent to the surgery because of weakness in his legs and orthopedic knee problems. When he fell, his spine was forcefully flexed pulling the cephalad portion of the rods out of the head of the L5 pedicle screw and likely breaking the locking screws. If this surgery was not approved, he will probably go on to require a failed fusion revision surgery. The current planned surgery was to see if the rods could be placed back in position and retighten the locking screws. It may not require any removal or placement of new hardware. The 5/14/15 addendum report to the 3/6/15 CT scan documented slippage of the posterior fixating rod inferiorly in relation to the bilateral L5 transpedicular screw heads. On the right, the rod had slipped anteriorly approximately 6 mm, and on the left, it had slipped inferiorly approximately 5 mm.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 re-exploration and hardware replacement: Overturned

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, Hardware Implant Removal.

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: Fusion (spinal); Hardware implant removal (fixation).

Decision rationale: The California MTUS do not address re-exploration or hardware replacement surgery. The Official Disability Guidelines (ODG) recommends revision surgery for failed previous operations if significant functional gains are anticipated. 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. Guideline criteria have been met. This patient presents status post L5/S1 instrumented fusion with significant pain following two falls. Clinical exam findings are consistent with imaging evidence of hardware slippage. The treating physician has opined the need to attend to reposition the rods and retighten the locking screws to avoid failed fusion. Therefore, this request is medically necessary.

Associated surgical services: Post-op physical therapy 3 x 6: 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.

Decision rationale: The California Post-Surgical Treatment Guidelines for lumbar fusion suggest a general course of 16 post-operative visits over 8 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course. If it is determined additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. Guideline criteria have not been met. An initial request for 8 visits and a total request not to exceed 16 visits would be supported. This request for post-op physical therapy exceeds recommendations for both initial post-surgical treatment and the general course of treatment. Therefore, this request is not medically necessary.