

Case Number:	CM13-0056424		
Date Assigned:	12/30/2013	Date of Injury:	02/14/2008
Decision Date:	06/23/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/22/2013

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 Surgery has a subspecialty in Spine Fellowship and is licensed to practice in California. 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 claimant is a 53 yo female who sustained an industrial injury on 02/14/2008. Her diagnoses include injury to her neck, arms, hands, and back. She is s/p C5-7 anterior cervical discectomy and fusion (ACDF) on 08/08/2012. The patient has undergone conservative care over the last 4 to 5 years, including physical therapy, medication, and activity modification. Medical record from 2013 and 2014 were reviewed, demonstrating chronic lumbar back pain despite conservative medical management. The patient reports severe and constant low back pain that radiates into the right posterior lateral thigh down into the right lateral ankle and foot. She reports that the leg is weak and she is intolerant to activity. 9/6/13 lumbar MRI demonstrates, at L5-S1, a 3-mm broad-based disk protrusion, slightly eccentric to the right gutter with mild to moderate right foraminal narrowing, but only equivocal contact of the exiting right L5 rootlet and no canal or lateral recess stenosis is present. Physical exam demonstrates a positive straight leg raise test on the right. There is decreased sensation in the right L5 and right S1 dermatomes. The treating provider has requested provider has requested an inpatient length of stay for one (1) night at [REDACTED], lumbar microdiscectomy at the L5-S1 level, an assistant surgeon, intra-operative neuro-monitoring and one unit of autologous blood.

IMR ISSUES, DECISIONS AND RATIONALES

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

INPATIENT LENGTH OF STAY FOR ONE (1) NIGHT AT [REDACTED]:
Upheld

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

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, Hospital Length of stay

Decision rationale: CA MTUS does not apply. ODG indicates a best practice target of outpatient treatment with discectomy only. The patient is certified for an associated request for a lumbar microdiscectomy at the L5-S1 level. However, ODG's best practice target is an outpatient procedure. Therefore, the request is not medically necessary.

LUMBAR MICRODISCECTOMY AT THE L5-S1 LEVEL: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE, CHAPTER 12: LOW BACK COMPLAINTS,

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Decompression

Decision rationale: CA MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair; and failure of conservative treatment. The patient presents with clinical L5 and S1 radiculopathy recalcitrant to prolonged course of conservative care. Imaging findings demonstrate, at L5-S1, a 3-mm broad-based disk protrusion, slightly eccentric to the right gutter with mild to moderate right foraminal narrowing. While the previous adverse determination was based on lack of objective radiculopathy, the focal neurologic sensory deficits are clearly in the corresponding dermatomes, and moderate foraminal narrowing corroborates the clinical diagnosis. Therefore, the request is medically necessary.

ASSISTANT SURGEON: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics

Decision rationale: American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics states on the role of the First Assistant: According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The patient is certified for an associated request for a lumbar microdiscectomy at the L5-S1 level. Therefore, the request is medically necessary.

INTRA-OPERATIVE NEUROMONITORING: Overturned

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

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, Neuromonitoring

Decision rationale: Intraoperative neurophysiological monitoring is utilized in attempts to minimize neurological morbidity from operative manipulations. The patient is certified for an associated request for a lumbar microdiscectomy at the L5-S1 level. Therefore, the request is medically necessary.

ONE (1) UNIT OF AUTOLOGOUS BLOOD: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Autotransfusers

Decision rationale: CA MTUS does not apply. [REDACTED] Clinical Policies indicate that autotransfusion may be indicated with procedures that may deplete blood volume. Autotransfusion and cell saver devices are considered experimental and investigational for all other indications. Autotransfusion and cell saver devices are not considered medically necessary for procedures that are expected to require less than two units of blood. However, there is no evidence that more than two units of blood loss would be expected with a single-level discectomy. Therefore, the request is not medically necessary.