

<b>Case Number:</b>	CM14-0170799		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	06/02/2011
<b>Decision Date:</b>	12/12/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery 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:

This is a 22 year-old male with a 6/2/11 injury date. He slipped on a floor that he was waxing and injured his lower back. In a 9/15/14 follow-up, subjective complaints included low back pain and bilateral leg pain in the posterior thighs and the sole of the left foot. Objective findings were normal. In an 8/26/14 follow-up, the neurologic exam was normal. In a 10/31/14 follow-up, the patient had good strength in his lower extremities, bilateral numbness that was worse on the left than the right. A lumbar MRI on 12/14/12 showed L3-4 stenosis due to large central disc herniation with no neural impingement, L4-5 central disc protrusion that is deviating the descending right L5 nerve root, and L5-S1 central disc extrusion to the left which deviates the left S1 nerve root. There was a prior approval of L3-4 and L4-5 decompression but the surgery was not done because of the patient's uncontrolled diabetes. The authorization for this request was apparently extended, but the surgeon wishes to add an additional level (left L5-S1) to the procedure. Diagnostic impression: lumbar herniated disc. Treatment to date: medications, physical therapy. A UR decision on 10/7/14 denied the request for left L5-S1 microdiscectomy on the basis that there were no objective findings of radiculopathy at that level. The requests for inpatient hospital stay and PA-C assistant were denied because the surgical procedure was not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Inpatient Hospital Stay (LOS) x1-2 Day: 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 address this issue. ODG recommends that a single-level discectomy be performed on an outpatient basis. However, the requested 1-2 day inpatient stay is outside the limits recommended by the guidelines. In addition, the surgical request could not be certified. Therefore, the request for Inpatient Hospital Stay (LOS) x1-2 Day is not medically necessary.

**PA-C Assistant:** 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: American Academy of Orthopedic Surgeons (AAOS)

**Decision rationale:** CA MTUS and ODG do not address this issue. American Academy 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 first assistant provides aid in exposure, hemostasis, and other technical functions, which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital. "The first assistant's role has traditionally been filled by a variety of individuals from diverse backgrounds. Practice privileges of those acting as first assistant should be based upon verified credentials reviewed and approved by the hospital credentialing committee (consistent with state laws)." In general, the more complex or risky the operation, the more highly trained the first assistant should be. Criteria for evaluating the procedure include: -anticipated blood loss - anticipated anesthesia time -anticipated incidence of intraoperative complications -procedures requiring considerable judgmental or technical skills -anticipated fatigue factors affecting the surgeon and other members of the operating team -procedures requiring more than one operating team. In limb reattachment procedures, the time saved by the use of two operating teams is frequently critical to limb salvage. It should be noted that reduction in costly operating room time by the simultaneous work of two surgical teams could be cost effective. However, in this case the request for assistant surgeon cannot be approved because the surgical procedure was not certified. Therefore, the request for PA-C assistant is not medically necessary.

**Left L5-S1 Microdiscectomy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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--Discectomy/laminectomy

**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. However, in this case it is not clear from the documentation if there is objective radiculopathy at L5-S1. There is no evidence of motor/sensory/reflex dysfunction at this level. There are no electrodiagnostic studies available for review. Therefore, the request for Left L5-S1 Microdiscectomy is not medically necessary.