

Case Number:	CM14-0174967		
Date Assigned:	10/28/2014	Date of Injury:	09/20/2009
Decision Date:	12/04/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/22/2014

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 59 year old male with a 9/20/09 injury date. He injured his back in a motor vehicle accident. In a 9/5/14 follow-up, subjective findings included severe lower back pain and bilateral leg pain. The patient also noted numbness and tingling in both legs with giving way of the right leg while jogging. Objective findings were negative for any motor/sensory/reflex dysfunction. The provider indicated that a procedure would not reliably improve his pain, although he did discuss possible removal of implants. The provider also noted that the patient has had real benefit from aqua therapy and exercise in the past, and strongly encouraged ongoing water exercise and physical therapy. Prior notes indicated that prior sensory deficits have been at the L3 and L4 distributions, with no evidence of L5 or S1 dysfunction. A 7/31/14 CT myelogram showed a solid fusion at L2 to S1 with the right S1 screw located medial to the pedicle, without stenosis or nerve compression. Electrodiagnostic studies were reportedly normal. Diagnostic impression: lumbar spondylosis. Treatment to date: L2-S1 lumbar fusion (9/13/12), physical therapy, aquatic therapy, medications, epidural steroid injection. A UR decision on 9/24/14 denied the request for removal of implants with revision laminectomies on the basis that there is no clear neurocompressive lesion, and there is a solid fusion from L2 to S1 with normal EMG/NVCs. The request for assistant surgeon was denied because the associated 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:

Removal of Implants with revision Laminectomies: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery, Discectomy/Laminectomy

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--Hardware removal.

Decision rationale: With regards to decompressive laminectomy, 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. With regards to hardware removal, ODG states that if a hardware injection can eliminate the pain by reducing the swelling and inflammation near the hardware, the surgeon may decide to remove the patient's hardware. However, in this case there is no recent MRI available for review that would show the presence of neurocompressive lesions, and the recent EMG was reportedly negative. The patient's symptoms and signs on exam do not correlate with the medially placed pedicle screw at right S1. The recent CT scan does not show any stenosis or other areas of compression. At this time there is insufficient evidence to support the necessity of the proposed procedure. Therefore, the request for removal of implants with revision laminectomies is not medically necessary.

Associated Services: Requesting Assistant Surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery, Discectomy/Laminectomy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopedic Surgeons (AAOS): Position statement on Reimbursement of the First Assistant at Surgery in Orthopedics.

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. Although an assistant surgeon is warranted given the complexity of this case, the request cannot be approved because the procedure was not certified. Therefore, the request for Associated Services: Assistant Surgeon is not medically necessary.