

Case Number:	CM14-0175023		
Date Assigned:	10/28/2014	Date of Injury:	08/25/2011
Decision Date:	12/12/2014	UR Denial Date:	09/20/2014
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 45 year old male with an 8/25/11 injury date. In a 9/10/14 follow-up, subjective findings included continued lower back pain with no radicular symptoms. Objective findings included focal tenderness at the L4 through S1 levels and intact motor strength testing. The patient stands with a list over to the side and is unable to fully flex or extend due to intractable back pain. The patient is currently working full duty with no limitations. A 7/29/14 lumbar MRI showed L5-S1 interval anterior fusion and moderate to severe bilateral neural foraminal stenosis at this level. A 9/12/14 lumbar CT showed: L5-S1 anterior lumbar interbody fusion with anterior fixation plates and screws. A lumbar spine SPECT scan on 9/5/14 showed moderate increased radiotracer activity at the L5-S1 disc space in the area of the previous fusion with no evidence of solid bony fusion on the CT images, suspicious for nonunion. Diagnostic impression: L5-S1 pseudoarthrosis. Treatment to date: medications, physical therapy, trigger point injections, lumbar spine fusion L5-S1 (1/29/13). A UR decision on 9/20/14 denied the request for posterior spinal fusion L5-S1 on the basis that there is no evidence of nonunion on the lumbar CT and MRI. The requests for inpatient stay, assistant surgeon, and medical clearance were 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:

Posterior Spinal Fusion L5-S1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Rager O, Schaller K, Payer M, Tchernin D, Ratib O, Tessitore E. SPECT/CT in differentiation of pseudarthrosis from other causes of back pain in lumbar spinal fusion: report on 10 consecutive cases. Clin Nucl Med. 2012 Apr;37(4):339-43.

Decision rationale: CA MTUS states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. In this case, there was no clear evidence of L5-S1 nonunion on recent MRI or CT imaging. However, it was not mentioned in the previous UR decision that a recent lumbar SPECT study on 9/5/14 did show increased radiotracer activity at L5-S1 that was suspicious for nonunion. It was shown in a recent study by Rager O et al. that SPECT imaging of the lumbar spine increases specificity for detection of nonunion of interbody devices compared to CT alone. In addition, the patient has a history of low back pain without radiation that has worsened since his L5-S1 fusion in 2013, and there is focal tenderness at L4 to S1 on exam. The presence of nonunion on lumbar SPECT imaging that correlates clinically is sufficient criteria for spinal instability. Therefore, the request for posterior spinal fusion L5-S1 is medically necessary.

3 Day In-Patient Stay: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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 (LOS).

Decision rationale: CA MTUS does not address this issue. ODG allows for a 3-day hospital stay after lumbar fusion. Therefore, the request for 3 day in-patient stay is medically necessary.

Assistant Surgeon: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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): 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. This case is of sufficient complexity to warrant the use of an assistant surgeon. Therefore, the request for assistant surgeon is medically necessary.

Medical clearance to include consult, labs/EKG/ CXR (Chest x-ray) as well as additional medically necessary testing for clearance: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

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-Preoperative EKG and lab testing. Other Medical Treatment Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery

Decision rationale: CA MTUS does not address this issue. ODG states that pre-op testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgeries who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. The associated surgical procedure is of intermediate risk and has been certified. Therefore, the request for medical

clearance to include consult, labs/EKG/CXR as well as additional medically necessary testing for clearance is medically necessary.