Case Number:	CM14-0034773		
Date Assigned:	06/20/2014	**Date of Injury:**	06/18/2012
Decision Date:	08/25/2014	**UR Denial Date:**	02/12/2014
Priority:	Standard	**Application Received:**	03/20/2014

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 42-year-old male patient with a 6/18/12 date of injury. The patient was crawling under a house and went under a beam. When he pushed off with his foot, he felt a pull in his back. A 1/24/14 progress report indicates persistent low back pain radiating to the left lower extremity. The patient reports that his leg has given out and his symptoms are fairly constant. The patient reports pain at night. Physical exam demonstrates antalgic gait, left quadriceps weakness, TA weakness, and EHL (extensor hallucis longus) weakness. Sensation is intact. Reflexes are diminished, but symmetric at the knees and ankles. Lumbar x-rays demonstrate slight asymmetric loss of disk height at the L5-S1 level with early degeneration. A 1/2/14 lumbar MRI demonstrates, at L5-S1, a 3-mm midline/left paracentral posterior disk osteophyte complex resulting in mild to moderate left neural foraminal stenosis; desiccated L5-S1 disk space, mild to moderate left neural foraminal stenosis and patent right neural foramen. Treatment to date has included physical therapy, lumbar ESI (epidural steroid injection), and medication. There is documentation of a previous 2/12/14 adverse determination for lack of documented instability and/or spondylolisthesis. A psychosocial clearance was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anterior lumbar Interbody Fusion (ALIF) insertion of biomechanical devices L-S1, Lumbar Laminectomy instrumented fusion L5-S1, Fluoroscopy, Autograft, allograft:
Upheld

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 Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Decompression, Fusion.

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. In addition, 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. However, there remains no evidence of dynamic instability, segmental spinal unit failure, or degenerative spondylolisthesis. Absent such findings, indications for associated fusions are not established. It is unclear whether the requested biomechanical devices are artificial disc replacements, which are not recommended in the lumbar spine. A psychological clearance was likewise not obtained. Therefore, the request for Anterior lumbar Interbody Fusion (ALIF) insertion of biomechanical devices L-S1, Lumbar Laminectomy instrumented fusion L5-S1, Fluoroscopy, Autograft, allograft is not medically necessary.

3-4 Inpatient Stay: 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's best practice target following lumbar fusion is 3 days inpatient stay. However, the associated request for Anterior lumbar Interbody Fusion (ALIF) insertion of biomechanical devices L-S1, Lumbar Laminectomy instrumented fusion L5-S1, Fluoroscopy, Autograft, allograft was deemed not medically necessary; therefore, the associated request of a 3-4 inpatient stay is also not medically necessary.

Assistant Surgeon: 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 Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

Decision rationale: CA MTUS and ODG do not apply. 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 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. However, the associated request for Anterior lumbar Interbody Fusion (ALIF) insertion of biomechanical devices L-S1, Lumbar Laminectomy instrumented fusion L5-S1, Fluoroscopy, Autograft, allograft was deemed not medically necessary; therefore, the associated request for an Assistant Surgeon is also not medically necessary.