

<b>Case Number:</b>	CM15-0198614		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	11/09/2007
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	10/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 61-year-old male, who sustained an industrial injury on 11-9-07. The injured worker has complaints of low back pain and continues to have right-sided quad atrophy as well as hip flexor and quad strength of 4+ out of 5. Lumbar spine x-rays showed L2 to S1 (sacroiliac) laminectomy and fusion, transforaminal lumbar interbody fusion (TLIF), no evidence of any hardware loosening or failure. Lumbar spine magnetic resonance imaging (MRI) on 6-25-15 revealed comparison with the prior magnetic resonance imaging (MRI) lumbar spine dated 3-23-15 demonstrates evidence for interval postsurgical changes at L2-L3 consistent with interbody fusion and pedicle screw fixation bilaterally at L2 and interval development of worsened spinal canal stenosis at L1 to L2. The diagnoses have included post laminectomy syndrome, lumbar region. Treatment to date has included status post L2 to S1 (sacroiliac) revision laminectomy and fusion on 6-2-15; physical therapy; methadone; Norco; Percocet; valium and oxycodone. The documentation on 8-5-15 noted that the injured worker has persistent deficits and continued pain and is potentially would be a candidate of revision and extending this fusion up to T10 and performing laminectomy, decompression and transforaminal lumbar interbody fusion (TLIF) at L1-2. The original utilization review (10-7-15) non-certified the request for spine revision T10 to S1 laminectomy fusion, transforaminal lumbar interbody fusion (TLIF); inpatient 3 days; associated surgical services; surgery assistant; pre-operation labs, complete blood count and basic metabolic panel; associated surgical services; chest x-ray and associated surgical services, electrocardiogram.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Spine Revision T10 to S1 Laminectomy Fusion, TLIF:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Fusion.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Fusion.

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, except for cases of trauma-related spinal fracture or dislocation, is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. According to the ODG, Low back, Fusion (spinal) should be considered for 6 months of symptom. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, ODG states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient, there is evidence of medical necessity for lumbar fusion as there is evidence of severe stenosis at L1-2, which remains symptomatic to warrant fusion. Therefore, the request is medically necessary.

### **Inpatient 3 days:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Hospital length of stay.

**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, Hospital length of stay.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of hospital length of stay following a lumbar fusion. According to the ODG, Low back section, Hospital length of stay, a 3-day inpatient stay is recommended following a posterior lumbar fusion. As a request is for 3 days, the request is medically necessary and appropriate.

### **Associated Surgical Services; surgery assistant:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Surgical assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Surgeons (<http://www.aaos.org/about/papers/position/1120.asp>).

**Decision rationale:** CA MTUS/ACOEM/ODG are silent on the issue of assistant surgeon. 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 function, 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. There is an indication for an assistant surgeon during a T10 to S1 revision fusion. The guidelines state that the more complex or risky the operation, the more highly trained the first assistant should be. In this case, the request is medically necessary and appropriate.

**Pre-operation labs- CBC, BMP:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Pre operative lab testing.

**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, Preoperative testing.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, that these investigations 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 that undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, based upon the extensive surgery planned, CBC and BMP is warranted prior to the proposed surgical procedure. Therefore, the request is medically necessary and appropriate.

**Associated Surgical Services; Chest x-ray:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Pre operative testing.

**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, Preoperative testing.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, that these investigations 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 that undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, based upon the extensive surgery planned the patient will be prone for a prolonged period of time. Therefore, a chest x-ray is warranted prior to the proposed surgical procedure. Therefore, the request is medically necessary and appropriate.

**Associated Surgical Services; EKG:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Pre operative testing.

**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, Preoperative testing.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, that these investigations 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 that undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, and based upon the extensive surgery planned, an EKG is warranted prior to the proposed surgical procedure.

Therefore, the request is medically necessary and appropriate.