Case Number:	CM14-0091860		
Date Assigned:	09/12/2014	**Date of Injury:**	07/26/2012
Decision Date:	10/14/2014	**UR Denial Date:**	06/02/2014
Priority:	Standard	**Application Received:**	06/17/2014

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 54 year old female with a 7/26/12 injury date. The mechanism of injury is not provided. In a follow-up on 3/19/14, subjective complaints included thoracic radicular pain that spreads to the rib areas, upper abdominal region, and above the umbilicus with painful paresthesias near the midline. Objective findings included numbness in the right intercostal region, paresthesias in the area of the upper abdominal region, near the umbilicus; and severe muscle spasms in the thoracic paraspinal musculature as well as in the latissimus dorsi region. Thoracic spine xrays on 3/5/14 showed scoliosis centered around the T8-9 and T9-10 area, concave to the left; and the T8-9, T9-10, and T10-11 discs are degenerated. No flexion/extension views were available. A thoracic spine MRI on 3/5/14 showed dessicated mild T8-9 thoracic spondylosis with moderate left neural foraminal stenosis, dessicated mild T9-10 thoracic spondylosis with moderate left neural foraminal stenosis, and no specific abnormality or impingement in the remaining levels. In the 3/19/14 follow-up, the treatment plan was 3-level (T8-9, T9-10, and T10-11) thoracic fusion with pedicle screws given the patient's incapacitating residual thoracic radicular pain. Diagnostic impression: thoracic radiculopathy.Treatment to date: s/p thoracic laminectomy of T9-10 (9/13/13), physical therapy, activity modification, medications.A UR decision on 6/2/14 denied the request for 3-level thoracic fusion on the basis that the MRI did not report any significant pathology at the proposed fusion level T10-11. In addition, there was no documentation of a condition/diagnosis for which fusion is indicated, such as instability. The requests for surgical assistant and 3-day hospital stay 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:

Surgery: Thoracic Fusion with screws: T 8-9, T9-10, T10-11 to be performed at [redacted]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): Page: 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter: Pages 382-383

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

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. ODG states that, until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." It appears that workers' compensation populations require particular scrutiny when being considered for fusion for chronic low back pain, as there is evidence of poorer outcomes in subgroups of patients who were receiving compensation or involved in litigation. In the present case, while the patient has subjective and objective findings consistent with thoracic radiculopathy, it is unclear why a fusion is necessary as opposed to a decompression. If the reason is because iatrogenic instability would be created after a 3-level decompression, then that would need to be stated in the documentation. Otherwise, thoracic spinal instability does not appear to already exist in this patient. There are no flexion/extension xrays and there is no spondylolisthesis reported on either the standard thoracic xray series or the MRI. In addition, there does not appear to be any significant pathology at the most caudal of the proposed fusion levels (T10-11) on MRI. Therefore, the request for Thoracic Fusion with screws: T 8-9, T9-10, T10-11 to be performed at [redacted] is not medically necessary.

Surgical 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. In the present case, the complexity is significant enough to warrant the use of an assistant surgeon. However, the assistant surgeon cannot be approved because the proposed surgical procedure was not certified. Therefore, the request for surgical assistant is not medically necessary.

Inpatient Hospital Stay: 3 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Hospital length of stay guidelines:Low back Lumbar & Thoracic Chapter

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.

Decision rationale: CA MTUS does not address this issue. ODG cites a recommended length of stay of 5 days after uncomplicated posterior thoracic fusion. The requested 3 days is within this limit, however, it cannot be approved because the proposed surgical procedure was not certified. Therefore, the request for inpatient hospital stay 3 days is not medically necessary.