
Notice of Independent Medical Review Determination

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:

[REDACTED]

[REDACTED]

Date of UR Decision:

6/4/2013

Date of Injury:

8/4/2010

IMR Application Received:

7/3/2013

MAXIMUS Case Number:

CM13-0000948

- 1) MAXIMUS Federal Services, Inc. has determined the request for **removal of spine fixation device is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **exploration of spine fusion is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **lumbar spine fusion is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **insert spine fixation device is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **removal of bone for graft is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **removal of fascia for graft is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **microsurgery add-on is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for **LSO sagittal coronal control is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for **MCCD risk adj level 3 is not medically necessary and appropriate.**

- 10)MAXIMUS Federal Services, Inc. has determined the request for **elec
ostreogen stim is not medically necessary and appropriate.**
- 11)MAXIMUS Federal Services, Inc. has determined the request for **DME MI is not
medically necessary and appropriate.**
- 12)MAXIMUS Federal Services, Inc. has determined the request for **sedation IV/IM
or inhalent is not medically necessary and appropriate.**
- 13)MAXIMUS Federal Services, Inc. has determined the request for **surgical trays
is not medically necessary and appropriate.**
- 14)MAXIMUS Federal Services, Inc. has determined the request for **delivery/set up
dispensing is not medically necessary and appropriate.**
- 15)MAXIMUS Federal Services, Inc. has determined the request for **sales tax is
not medically necessary and appropriate.**
- 16)MAXIMUS Federal Services, Inc. has determined the request for **removal of
support implant is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/3/2013 disputing the Utilization Review Denial dated 6/4/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/5/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **removal of spine fixation device** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **exploration of spine fusion** is not medically necessary and appropriate.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **lumbar spine fusion** is not medically necessary and appropriate.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **insert spine fixation device** is not medically necessary and appropriate.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **removal of bone for graft** is not medically necessary and appropriate.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **removal of fascia for graft** is not medically necessary and appropriate.
- 7) MAXIMUS Federal Services, Inc. has determined the request for **microsurgery add-on** is not medically necessary and appropriate.
- 8) MAXIMUS Federal Services, Inc. has determined the request for **LSO sagittal coronal control** is not medically necessary and appropriate.
- 9) MAXIMUS Federal Services, Inc. has determined the request for **MCCD risk adj level 3** is not medically necessary and appropriate.
- 10) MAXIMUS Federal Services, Inc. has determined the request for **elec osteogen stim** is not medically necessary and appropriate.
- 11) MAXIMUS Federal Services, Inc. has determined the request for **DME MI** is not medically necessary and appropriate.
- 12) MAXIMUS Federal Services, Inc. has determined the request for **sedation IV/IM or inhalent** is not medically necessary and appropriate.
- 13) MAXIMUS Federal Services, Inc. has determined the request for **surgical trays** is not medically necessary and appropriate.
- 14) MAXIMUS Federal Services, Inc. has determined the request for **delivery/set up dispensing** is not medically necessary and appropriate.
- 15) MAXIMUS Federal Services, Inc. has determined the request for **sales tax** is not medically necessary and appropriate.

16)MAXIMUS Federal Services, Inc. has determined the request for **removal of support implant is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Spinal 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

This is a 51 year old male with date of injury, 8/4/10, to lumbar spine, cervical spine, and right upper extremity. The patient is status post fusion on 8/14/12 at L4-S1 for Grade I spondylolisthesis at L5/S1. It is noted on 1/17/13, the patient complained of low back pain. There was discussion regarding CT scan in the future. Radiographs dated 4/15/13, demonstrates posterior fusion L4-S1 without hardware failure. No acute osseous abnormality is seen. CT scan of lumbar spine from 4/27/13 demonstrates fusion from L4-S1. The report on 5/30/13, of an inadequate CT scan is without sagittal and coronal reconstructions. Request is for hardware removal of lumbar spine with exploration of fusion and reinstrumentation.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for removal of spine fixation device :

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), low back chapter: Spinal Fusion, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), low back chapter: Spinal Fusion, and the Milliman Care Guidelines 17th edition.

Rationale for the Decision:

Official Disability Guidelines state in regards to hardware implant removal (fixation), "Not recommend the routine removal of hardware implanted for fixation", except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. The guidelines do not recommend solely to protect against allergy, carcinogenesis, or metal detection. According to the medical records provided for review the radiographs from 4/15/13 demonstrates posterior fusion of L4-S1 without hardware failure, and no acute osseous abnormality are seen. Computed tomography (CT) scan of the lumbar spine from 4/27/13 demonstrates fusion from L4-S1. The medical report dated 5/30/13 reveals inadequate CT scan results due to the lack of sagittal and coronal reconstructions. In this case there is no evidence of pseudarthrosis to warrant surgical exploration of fusion. **The request for removal of spine fixation device is not medically necessary and appropriate.**

2) Regarding the request for exploration of spine fusion :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

3) Regarding the request for lumbar spine fusion :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

4) Regarding the request for insert spine fixation device :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

5) Regarding the request for removal of bone for graft :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

6) Regarding the request for removal of fascia for graft :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

7) Regarding the request for microsurgery add-on :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

8) Regarding the request for LSO sagittal coronal control :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

9) Regarding the request for MCCD risk adj level 3:

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

10) Regarding the request for elec osteogen stim :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

11) Regarding the request for DME MI:

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

12) Regarding the request for sedation IV/IM or inhalent:

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

13) Regarding the request for surgical trays :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

14) Regarding the request for delivery/set up dispensing :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

15) Regarding the request for sales tax :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

16) Regarding the request for removal of support implant :

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/mg

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.