**MAXIMUS FEDERAL SERVICES, INC.**
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

# Independent Medical Review Final Determination Letter

December 19, 2013

| | |
|---|---|
| Employee: | |
| Claim Number: | |
| Date of UR Decision: | 7/10/2013 |
| Date of Injury: | 2/14/2011 |
| IMR Application Received: | 8/5/2013 |
| MAXIMUS Case Number: | CM13-0011223 |

Dear Mr./Ms.

MAXIMUS Federal Services has completed the Independent Medical Review ("IMR") of the above workers' compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations,

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopaedic Surgery, and is licensed to practice in New Hampshire, New York, and Washington. 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 physician 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.

## DOCUMENTS REVIEWED

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

- [redacted]
- [redacted]
- [redacted]
- [redacted]

## CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The first reported date of injury is 2/25/2011 with minor trauma. Patient has a history of chronic back and leg pain in May 2013. He also complained of right leg aching,numbness,and stiffness. He has a physical exam finding of limited back range of motion and EHL and knee flexion weakness and a positive straight leg raise test. BMI was 30.87. He pain improved with unspecified medications, but got worse with cold weather. He was diagnosed with s/p left l5-s1 discectomy surgery on 7/31/2012 and postlaminectomy syndrome, chronic left radicular pain, and axial back pain. He has a lumbar MRI from 11/15/2012 that shows multiple levels of degeneration to include both L4-5 and L5-s1 along with scar tissue at left L5-S1 previous surgery site and a 5mm central to left L5-S1 disc protrusion. There is granulation tissue signal around the left S1 nerve root consistent with previous surgery. There is not imaging evidence of instability. The patient had transforminal steroid injection that provided 80% relief of pain. He had 2 lumbar epidurals without relief of back pain. Another L2-3 block had 4-5 days of reported symptom relief. He had 6 sessions of physical therapy but could not tolerate it. He has also had cold packs, heat, and lumbar bracing. At issue is whether or not ALIF L5-S1 fusion surgery is medically needed.

## IMR DECISION(S) AND RATIONALE(S)

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

**1. L5-S1 anterior lumbar interbody fusion is not medically necessary and appropriate.**

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Low Back Complaints, pgs. 308-310, Summary of Recommendations and Evidence, which is part of the MTUS.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Low Back Complaints, pg. 307, Spinal Fusion, which is part of the MTUS.

The Physician Reviewer's decision rationale:
This employee had previous L5-S1 discectomy surgery and still has back and leg pain. The latest MRI imaging study shows scar tissue in the region of surgery with a 5mm disk bulge and multiple levels of lumbar disk degeneration without documented radiographic evidence of instability at any lumbar segment . The employee does not meet established criteria for lumbar fusion. There is also no evidence of fracture, or concern for tumor. Lumbar fusion surgery is not more likely than conservative measures to relieve the employee's back pain. Surgery is not medically necessary and not supported in the current peer review literature. All associated measures with the surgery are not needed. **The request for L5-S1 anterior lumbar interbody fusion is not medically necessary and appropriate.**

**2. Bone morphogenic protein (BMP) is not medically necessary and appropriate.**

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

**3. Demineralized bone matrix (DBM) is not medically necessary and appropriate.**

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

**4. Assistant surgeon is not medically necessary and appropriate.**

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

**5. 2-3 days inpatient stay is not medically necessary and appropriate.**

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

**6. Pre-op consultation is not medically necessary and appropriate.**

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

**7. Front wheel walker is not medically necessary and appropriate.**

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

**8. Raised toilet seat is not medically necessary and appropriate.**

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

**9. Cold therapy unit is not medically necessary and appropriate.**

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

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.

[redacted]

CM13-0011223