
Notice of Independent Medical Review Determination

Dated: 8/29/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/5/2013
Date of Injury:	10/29/2003
IMR Application Received:	7/11/2013
MAXIMUS Case Number:	CM13-0001249

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 posterior lumbar interbody fusion at L3-L4, L4-L5 and L5-S1 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/11/2003 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/15/2013. 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 1 posterior lumbar interbody fusion at L3-L4, L4-L5 and L5-S1 **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, 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 5, 2013:

“Clinical Rationale

The patient is a 49 year old male with a date of injury of 10/29/2003. Under consideration is a prospective request for authorization/certification of 1 posterior lumbar interbody fusion at L3-L4, L4-L5 and L5-S1, 1 prescription of Sumatriptan 25mg, 1 prescription of Ultram 50mg #60, 1 prescription of Ambien 20mg #30. 1 prescription of Ibuprofen 800mg #90 and 1 prescription of Vicodin 7.5/750 mg # 120.

“Clinically speaking, this is a status post C5-7 arthrodesis with instrumentation patient with chronic and ongoing spine and lower extremity complaints, feeling of swelling of the legs, continuing and increasing headaches, neck pain and continuing right elbow pain. Objectively, there is a notation of a healed anterior cervical spine surgical incision, restricted cervical mobility with spasm in the paraspinal musculature, positive foraminal compression test, restricted right shoulder mobility, positive impingement test, tenderness over the greater tuberosity, subacromial grinding and clicking, restricted right elbow mobility, a positive Tinel's over the cubital tunnel syndrome, tenderness over the lateral epicondyle, restricted lumbar mobility with spasm in the paraspinal musculature, hyperesthesia at the anterolateral aspect of the foot and ankle in the L4-L5 and L5-S1 distribution, restricted left knee mobility, medial joint line tenderness, positive chondromalacia and McMurray's test over the medial meniscus and restricted mobility in the right foot and ankle with lateral joint line tenderness.

“On 02/23/2013, MRI with contrast of the C/S with flexion and extension views was completed and interpreted by the radiologist as there being reversal of the cervical curve, early disc desiccation throughout the spine, surgically fused from C5-7 with a two

level anterior fixation device/metal plate and screws spanning from C5-7, no abnormal enhancement with contrast, at C3-4 there is a diffuse disc protrusion effacing the thecal sac, at C4-5 there is a central focal disc extrusion with inferior migration and annular tear with indentation of the thecal sac and a retrolisthesis of C4 on C5. On 04/23/2012, MRI without contrast of the L/S with flexion and extension views was completed and interpreted by the radiologist as there being disc desiccation from L4-S1 with minimal disc height loss at L5-S1, loss of the lordosis, diastematomyelia at L1-2, annular tears from L3-S1, diffuse disc protrusion at L3—L4 with thecal effacement with bilateral neural foraminal narrowing that effaces the L3 nerve roots, diffuse right eccentric disc protrusion at L4-5 with thecal effacement with bilateral neural foraminal narrowing that Effaces the L4 Nerve roots, right<left, focal disc protrusion with caudal extrusion at L5-S1 with thecal effacement with bilateral neural foraminal narrowing, left<right, with the nerve roots unremarkable and a retrolisthesis of L5 on S1. On 03/05/2007, L/S discography was completed by the provider (orthopedic surgeon) recommending surgery as there being a positive discogram study at L4-5 and L5-S1 with a negative study at L4-L5 and L5-S1 with a negative study at the control disc (L3-L4). Urine drug screen was completed in 06/2012 with no corresponding documentation of inconsistent use of prescribed medications.

“Therapeutically, in addition to the previously noted surgical intervention, there is documentation of activity modification and the oral use of medication to include NSAID, opiate, non-benzodiazepine and benzodiazepines. There have also been numerous cervical and lumbar spine facet injections completed.”

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 for Independent Medical Review (received 7/11/2013)
- Utilization Review Determination by [REDACTED] (dated 7/5/13)
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, Lumbosacral Nerve Root Decompression, Spinal Fusion, Table 12-8, pg. 305-307
- Medical Records from [REDACTED], MD (dated 9/13/12 – 1/17/13)
- Medical Records from [REDACTED] (dated 8/9/13 – 5/23/13)
- Medical Records from [REDACTED] (dated 7/9/11 – 10/20/12)
- MRI cervical spine (dated 2/23/13)
- Report from [REDACTED] (dated 8/9/12)
- Ultrasound bilateral lower extremities (dated 8/1/12)

1) Regarding the request for 1 posterior lumbar interbody fusion at L3-L4, L4-L5 and L5-S1:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, Lumbosacral Nerve Root Decompression, pg. 306, and Spinal Fusion, pg. 307, part of the Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines (ODG) (current version), Low Back – Lumbar, & Thoracic, Patient Selection Criteria for Lumbar Spinal Fusion, a medical treatment guideline (MTG) not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the MTUS ACOEM guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 10/29/2003 the employee sustained a work-related injury. Treatment included a neuroplasty with segmental spinal decompression, multiple epidural steroid injections, MRIs, and medications. A medical report dated 5/16/13 indicates the employee continues to experience back and lower extremity pain, headache and right elbow pain. A request was submitted for a posterior lumbar interbody fusion at L3-L4, L4-L5 and L5-S1.

CA MTUS ACOEM guidelines suggest that lumbar fusion can be considered if there is structural instability introduced either iatrogenically or in degenerative spondylolisthesis. Spondylolisthesis is present at one level in this case as evidenced in an MRI report dated 2/23/13. However, in the absence of significant three-level disc pathology and the absence of instability on spinal examination, the medical records reviewed document no criteria for three-level spinal surgery. The request for a posterior lumbar interbody fusion at L3-L4, L4-L5 and L5-S1 **is not medically necessary and appropriate.**

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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

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

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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.