
Notice of Independent Medical Review Determination

Dated: 10/14/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/2/2013
Date of Injury: 4/16/1997
IMR Application Received: 7/18/2013
MAXIMUS Case Number: CM13-0001920

- 1) MAXIMUS Federal Services, Inc. has determined the request for an anterior lumbar interbody fusion with instrumentation and infusion allograft at L4-L5 and L5-S1 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a posterior lumbar interbody fusion, instrumentation, and decompression at L4-L5 and L5-S1 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for preoperative laboratory tests **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for preoperative electrocardiography and chest x-ray **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for neuromonitoring **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for 1 assistant surgeon **is not medically necessary and appropriate.**

- 7) MAXIMUS Federal Services, Inc. has determined the request for 1 vascular co-surgeon **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for a bedside commode **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for 1 preoperative medical clearance **is not medically necessary and appropriate.**
- 10) MAXIMUS Federal Services, Inc. has determined the request for 1 front wheel walker **is not medically necessary and appropriate.**
- 11) MAXIMUS Federal Services, Inc. has determined the request for a 14-day inpatient subacute hospital stay **is not medically necessary and appropriate.**
- 12) MAXIMUS Federal Services, Inc. has determined the request for 12 postoperative physical therapy sessions **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/22/2013. 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 an anterior lumbar interbody fusion with instrumentation and infusion allograft at L4-L5 and L5-S1 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a posterior lumbar interbody fusion, instrumentation, and decompression at L4-L5 and L5-S1 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for preoperative laboratory tests **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for preoperative electrocardiography and chest x-ray **is not medically necessary and appropriate.**
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- 6) MAXIMUS Federal Services, Inc. has determined the request for 1 assistant surgeon **is not medically necessary and appropriate.**
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- 9) MAXIMUS Federal Services, Inc. has determined the request for 1 preoperative medical clearance **is not medically necessary and appropriate.**
- 10) MAXIMUS Federal Services, Inc. has determined the request for 1 front wheel walker **is not medically necessary and appropriate.**
- 11) MAXIMUS Federal Services, Inc. has determined the request for a 14-day inpatient subacute hospital stay **is not medically necessary and appropriate.**
- 12) MAXIMUS Federal Services, Inc. has determined the request for 12 postoperative physical therapy sessions **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 Orthopaedic 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 2, 2013:

The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The mechanism of injury was noted as a strain. The patient's medication

regimen included glyburide, metformin, ibuprofen, and Norco as needed. Surgical history included right shoulder arthroscopy with subacromial decompression, distal clavicle resection, arthroscopic rotator cuff repair and excision of loose bodies with an injection of Marcaine. Diagnostic studies included an MRI of the lumbar spine dated 12/26/2012 by Dr. [REDACTED] which revealed: (1) very mild dextroscoliosis and (2) multilevel degenerative disc disease with the most significant disease at the levels of L4-5 and L5-S1; specifically at the left 45 level there was marked spinal canal stenosis, marked narrowing the lateral recess and moderatenarrowing of the right neural foramen secondary to a 6 mm to 7 mm broad based diffuse disc bulge, facet joint arthropathy and ligamentum flavum hypertrophy. The spinal canal measured 9 mm in AP diameter and significantly smaller as compared to the other levels. There may be an extruded disc fragment along the inferior and lateral margin of the left neural foramen. At the L5-S1 level, there was a 6 mm broad based diffuse disc bulge which resulted in moderate narrowing of the left lateral recess. Moderate narrowing of the left neural foramen, marked narrowing of the right lateral recess, and moderate to marked narrowing of the right neural foramen. The disc contacts the undersurface of the exiting right L5 nerve. The spinal canal was adequate in caliber and measured 12 mm in AP diameter. The facet joint appeared normal. The ligamentum flavum was not thickened. Other therapies included physical therapy, frequency and duration not stated. The request for re-review of 1 vascular co-surgeon, 1 preoperative medical clearance, 1 anterior lumbar interbody fusion with instrumentation and infusion allograft at the levels of L4-5 and L5-S1 and 1 posterior lumbar interbody fusion, instrumentation and decompression at the L4-5 and L5-S1 level medically necessary is non certified. The clinical documentation submitted for review evidenced the patient continued to present with moderate complaints of lumbar spine pain status post a work related injury in 1997. Imaging of the patient's lumbar spine evidenced multilevel degenerative disc disease to the lumbar spine. The provider is recommending that the patient undergo posterior and anterior interbody fusion; however, the provider did not evidence rationale for the requested surgical intervention. There was no evidence of instability to the patient's lumbar spine to support a posterior and anterior fusion. Additionally, the clinical notes lacked evidence of a psychological evaluation of the patient prior to the requested surgical intervention, as recommended via guidelines, to address any confounding issues that may impede upon postoperative recovery. Furthermore, the provider documented that the patient recently utilized physical therapy; however, duration, frequency, and modalities utilized were not evidenced. The clinical notes did not indicate if the patient had attempted injection therapy for his radiculopathic symptoms to the bilateral lower extremities. The current request is for reconsideration, however, no new clinical notes were submitted for review to evidence support in the requested surgical procedure. Given all of the above, the request for re-review of 1 vascular

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
- Utilization Review from Claims Administrator
- California Medical Treatment Utilization Schedule (MTUS)
- Medical records from Claims Administrator

Description	Document Date
[REDACTED]	DOS 07/11/2012-07/11/2012 7/11/12
[REDACTED]	DOS 08/06/2012-08/06/2012 8/6/12
[REDACTED]	DOS 09/05/2012-09/05/2012 9/5/12
[REDACTED]	DOS 10/03/2012-10/03/2012 10/3/12
[REDACTED]	DOS 10/31/2012-10/31/2012 10/31/12
DR [REDACTED] - 11/30/12	11/30/12
[REDACTED]	DOS 12/03/2012-12/03/2012 12/3/12
[REDACTED];	DOS 12/04/2012-12/04/2012 12/4/12
[REDACTED] MD dos - 12/19/12	12/19/12
MRI RPT	12/26/12
MRI RPT	12/27/12
[REDACTED] - 12/28/12	12/28/12
[REDACTED]	1/2/13
[REDACTED] MD INC;	DOS 01/10/2013-01/10/2013 1/10/13
[REDACTED]	DOS 02/04/2013 2/4/13
[REDACTED]	DOS 02/13/13 2/13/13
[REDACTED]	DOS 02/19/2013-02/19/2013 2/19/13
[REDACTED] RNFA;	DOS 02/22/2013-02/22/2013 2/22/13
[REDACTED] dos	3/01/2013 3/1/13
[REDACTED]	DOS 03/06/2013-03/06/2013 3/6/13
[REDACTED]	DOS 03/13/2013-03/13/2013 3/13/13
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[REDACTED]	DOS 05/06/2013-05/06/2013 5/6/13
[REDACTED]	DOS 05/08/2013-05/08/2013 5/8/13
[REDACTED]	DOS 05/10/2013-05/10/2013 5/10/13
[REDACTED]	DOS 05/22/2013-05/22/2013 5/15/13
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[REDACTED]	DOS 06/14/2013-06/14/2013 6/10/13
[REDACTED]	DOS 06/18/2013-06/18/2013 6/12/13
[REDACTED]	DOS 06/19/2013-06/19/2013 6/14/13
[REDACTED]	6/18/13
[REDACTED]	6/19/13

1) Regarding the request for an anterior lumbar interbody fusion with instrumentation and infusion allograft at 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, page 307, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 4/16/1997 with what was noted as a strain. The employee has experienced lumbar spine pain. Treatment has included diagnostic studies, prior surgeries, physical therapy, and medications. A request was submitted for an anterior lumbar interbody fusion with instrumentation and infusion allograft at L4-L5 and L5-S1.

The ACOEM Guidelines indicate that within the first three months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disk) is detected. The guideline indicates that referral for surgical consultation is indicated for patients who have: (1) severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; (2) activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; (3) clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair; and/or (4) failure of conservative treatment to resolve disabling radicular symptoms

There were no clinical notes provided to document medical necessity for this procedure. The guideline criteria are not met. The request for an anterior lumbar interbody fusion with instrumentation and infusion allograft at L4-L5 and L5-S1 is not medically necessary and appropriate.

2) Regarding the request for a posterior lumbar interbody fusion, instrumentation, and decompression at 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, page 307, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 4/16/1997 with what was noted as a strain. The employee has experienced lumbar spine pain. Treatment has included diagnostic studies, prior surgeries, physical therapy, and medications. A request was submitted for an anterior lumbar interbody fusion with instrumentation and infusion allograft at L4-L5 and L5-S1.

The ACOEM Guidelines indicate that within the first three months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disk) is detected. The guideline indicates that referral for surgical consultation is indicated for patients who have: (1) severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; (2) activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; (3) clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair; and/or (4) failure of conservative treatment to resolve disabling radicular symptoms

There were no clinical notes provided to document medical necessity for this procedure. The guideline criteria are not met. The request for an anterior lumbar interbody fusion with instrumentation and infusion allograft at L4-L5 and L5-S1 is not medically necessary and appropriate.

3) Regarding the request for preoperative laboratory tests:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

4) Regarding the request for preoperative electrocardiography and chest x-ray:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

5) Regarding the request for neuromonitoring:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

6) Regarding the request for 1 assistant surgeon:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

7) Regarding the request for 1 vascular co-surgeon:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

8) Regarding the request for a bedside commode:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

9) Regarding the request for 1 preoperative medical clearance:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

10) Regarding the request for 1 front wheel walker:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

11) Regarding the request for a 14-day inpatient subacute hospital stay:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

12) Regarding the request for 12 postoperative physical therapy sessions:

Rationale for the Decision:

Since the primary procedures are not medically necessary and appropriate, none of the associated services are 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.