

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/19/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/11/2013
Date of Injury: 1/8/2003
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003376

DEAR [REDACTED]

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, [REDACTED]
/MCC

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 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 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:

This claimant is a 52-year-old male with a reported date of injury of 07/16/2012. The mechanism of injury was not specified other than that he was a police officer with back pain. He was seen in clinic in 12/2012 at which time x-rays demonstrated degenerative changes compatible with postoperative changes in the lumbar spine. Pain was rated at 7/10 and he denied smoking. Examination revealed decreased range of motion, muscle spasms, and guarding. Sensation was normal to light touch from L3 to S1 and deep tendon reflexes were 2+ bilaterally. An MRI was obtained which revealed that at L5-S1, there was a laminotomy defect with mild left lateral recess stenosis and mild to moderate foraminal stenosis secondary to asymmetric lateral disc/osteophyte complex. X-ray of the lumbar spine on 04/16/2013 revealed mild discogenic disease from L1 through L5 with moderate to severe discogenic disease at L5-S1. There was no evidence of abnormal lumbar motion. There was evidence of a prior posterior decompression at L5-S1. A CT performed on 06/27/2013 showed marked loss of disc height with vacuum phenomena at L5-S1 with a 5 mm endplate osteophyte, asymmetric to the left. There was also bilateral facet arthropathy resulting in moderate to severe degree of left greater than foraminal stenosis. Upon last evaluation on 07/30/2013, he had decreased strength in the right ankle dorsiflexors tibialis anterior, with grade 2 extension also weak at 4/5. He reported decreased sensation in the lateral leg and dorsum of the foot in an L5 distribution on the right. Straight leg raise was positive. Diagnoses include degeneration of thoracic and lumbar intervertebral disc, spinal stenosis and thoracic or lumbosacral neuritis or radiculitis. Plan at that time was to undergo an L5-S1 lumbar decompression with fusion and instrumentation with an assistant surgeon, intraoperative monitoring, and use of a pre-op medical clearance. One back brace and 12 postoperative physical therapy sessions were also requested as well as 1 cold therapy unit, 1 bone growth stimulator, and 3 days of inpatient stay.

IMR DECISION(S) AND RATIONALE(S)

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

1. L5-S1 lumbar decompression with fusion and instrumentation is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 12 (Low Back Complaints) (2004) pg. 305, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pages 305-307, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The medical records provided for review do not include a psychosocial evaluation as recommended by ACOEM Guidelines, and the records do not indicate the current status of this employee, as the last clinical note was of 07/30/2013. This employee does have stenosis and postlaminectomy defects seen at L5-S1. Furthermore, the last clinical note provided for this review was dated 07/30/2013 and the current clinical status of this employee is not documented for the records. The findings on last clinical exam do not correlate with imaging results, with complaints on exam being right-sided and imaging showing more pathology to the left side. There is also lack of documentation of current failure of lesser measures. A rationale for the proposed procedure in the form of an L5-S1 lumbar decompression with fusion and instrumentation has not been provided. **The request for L5-S1 Lumbar Decompression with fusion and instrumentation is not medically necessary and appropriate.**

2. One Assistant Surgeon between 7/1/2013 and 11/7/2013 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Centers for Medicare & Medicaid Services (CMS) <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>, which is not part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision on the American College of Surgeons, Physicians as Assistants at Surgery (2011.)

The Physician Reviewer's decision rationale:

In a study entitled Physicians as Assistants at Surgery, the American College of Surgeons indicate that assistant surgeons may be considered reasonable if there is documentation that the procedure may require considerable judgment or technical skills, if there is an anticipated lengthy anesthesia time, if there is significant anticipated blood loss, or if there is anticipated fatigue factors that would affect the surgeon and other members of the operating team. However, the medical records provided for this review do not document the current status of this employee and do not include a psychosocial evaluation. The findings on physical exam do not correlate with the imaging studies as recommended. At this time as there is no anticipated anesthesia time, no anticipated blood loss to be significant, and the procedure would not require considerable judgment of technical skills as the procedure is non-certified. **Since the primary procedure is not medically necessary, none of the associated services are medically necessary.**

3. One Intra-Operative Monitoring is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, Low Back-Lumbar & Thoracic Section (Acute & Chronic), which is not part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision on the Official Disability Guidelines Low Back Chapter, section on Intra-Operative Monitoring.

The Physician Reviewer's decision rationale:

The surgical procedure itself has not been considered reasonable and necessary due to a lack of a psychosocial evaluation, lack of conservative documentation of significant current conservative care, lack of documentation of the current status of this patient, and imaging studies not corresponding with physical exam in the medical records provided for review. **Since the primary procedure is not medically necessary, none of the associated services are medically necessary.**

4. Pre-op Medical Clearance is not medically necessary and appropriate.

The Claims Administrator based its decision on the Surgery General Information Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93, which is not part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision on the Official Disability Guidelines Low Back Chapter, section on Pre-Operative Testing.

The Physician Reviewer's decision rationale:

The surgical intervention itself is not considered medically necessary due to lack of physical findings that correlate with imaging studies, lack of documentation of significant current conservative care, lack of psychosocial evaluation, and lack of documentation of the current status of this employee in the medical records provided for review. **Since the primary procedure is not medically necessary, none of the associated services are medically necessary.**

5. One Back Brace is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, Low Back-Lumbar & Thoracic Section (Acute & Chronic), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) page 300, which is part of the MTUS, and the Official Disability Guidelines Low Back Chapter, section on Post-Fusion Brace, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The Official Disability Guidelines back chapter indicates that a post fusion brace is not absolutely necessary, but may provide some comfort to the patient and an off the shelf version is favored over a custom brace. The medical records provided for review do not indicate this employee is in the acute phase. **Since the primary procedure is not medically necessary, none of the associated services are medically necessary.**

6. Twelve Post-Op Sessions of Physical Therapy for Lumbar Spine between 7/10/2013 and 1/06/2014 is not medically necessary and appropriate.

The Claims Administrator based its decision on the California Post-Surgical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Postsurgical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer's decision rationale:

MTUS postsurgical guidelines indicate that for this procedure the initial request should be one half of the recommended allowable visits. For this procedure, 34 visits over 16 weeks would be considered reasonable per post-op guidelines. However, the surgical procedure itself has not been considered medically necessary and therefore no rationale has been given for postoperative physical therapy at this time. **Since the primary procedure is not medically necessary, none of the associated services are medically necessary.**

7. One Cold Therapy Unit between 7/10/2013 and 1/6/2014 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, Knee & Leg Section (Acute & Chronic) which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pages 298-300, which is part of the MTUS

The Physician Reviewer's decision rationale:

ACOEM Guidelines indicate that local applications of cold can be beneficial. The medical records provided for review do not indicate this employee has experienced any significant issues in the form of swelling at this time. The surgical procedure itself is not considered medically necessary and a rationale for a cold therapy at this time has not been provided. **Since the primary procedure is not medically necessary, none of the associated services are medically necessary.**

8. One Bone Growth Stimulator between 7/10/2013 and 1/6/2014 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, Low Back-Lumbar & Thoracic Section (Acute & Chronic), which is not part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision on the Official Disability Guidelines Low Back Chapter, section on Bone Growth Stimulators.

The Physician Reviewer's decision rationale:

According to the Official Disability Guidelines, use of a bone growth stimulator would be considered reasonable and necessary under certain conditions such as a multilevel fusion or previous pseudoarthrosis or documentation of smoking or other comorbidities such as diabetes. However, the surgical procedure has not been considered medically necessary as there is lack of documentation of psychosocial evaluation, physical findings do not correlate with imaging studies, there is a lack of documentation of significant current conservative care, and there is lack of documentation of the current status of this employee in the medical records provided for review. **Since the primary procedure is not medically necessary, none of the associated services are medically necessary.**

9. Three Day Inpatient Stay Between 7/10/2013 and 1/6/2014 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, ICD-9 Index, which is not part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision on the Official Disability Guidelines Low Back Chapter, section on Hospital Length of Stay.

The Physician Reviewer's decision rationale:

Official Disability Guidelines indicate that a three day inpatient stay would be considered reasonable for this type of surgical procedure. However, as the surgical procedure is not considered reasonable and necessary at this time, there is no need for a 3 day inpatient stay. **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.

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