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**Notice of Independent Medical Review Determination**

Dated: 11/14/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/23/2013  
Date of Injury: 3/1/2012  
IMR Application Received: 7/31/2013  
MAXIMUS Case Number: CM13-0005173

- 1) MAXIMUS Federal Services, Inc. has determined the request for **L4-5 explore fusion is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **L3-4 discectomy is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **possible fusion is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **assistant surgeon is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Aspen LSO lumbar brace is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **external bone growth stimulator is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/31/2013 disputing the Utilization Review Denial dated 7/23/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/12/2013. 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 **L4-5 explore fusion is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **L3-4 discectomy is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **possible fusion is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **assistant surgeon is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Aspen LSO lumbar brace is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **external bone growth stimulator is not medically necessary and appropriate.**

### Medical Qualifications of the Expert Reviewer:

The independent Medicine 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.

### Expert Reviewer Case Summary:

This claimant is a 33-year-old male with complaints of back pain. On 06/26/2013, he was taken to surgery by [REDACTED], MD and underwent an L4-5 posterior spinal fusion, L4-5 posterior spinal instrumentation, L4-5 Gill-type decompressive laminectomy/facetectomy, and L4-5 transforaminal lumbar interbody fusion with use of synthetic cage for arthrodesis at L4-5. 09/05/2012 until 09/26/2012, he underwent physical therapy. On 10/01/2012, he returned to clinic stating he still had a lot of pain to his back from sensation of feeling the hardware. He had more normal strength against resistance and there was no foot drop. He was able to do heel and toe walk well and sensation distally remained failure improved at that time. On 12/07/2012, an MRI of the lumbar spine was obtained demonstrating mild hypolordosis, mild degenerative disc disease, and post-surgical changes at the L4 and L5 levels. At the L3-4 level, there was

posterolateral disc protrusion with mild spinal stenosis and fissuring of the annular fibrosis and suspected mild impingement on the left L3 nerve root at the left neural foramen. There were no significant interval changes noted. At L4-5, there was fibrous or inflammatory tissue surrounding the thecal sac causing impingement of the left L4 nerve root at the lateral recess and possible impingement of the right L5 nerve root at the right neural recess. On 02/22/2013, lumbar spine x-rays were obtained demonstrating protrusion of the right L5 pedicle screw into the L4-5 intervertebral disc space. There was a grade I retrolisthesis at L3-4. CT scan performed on 02/22/2013 again revealed protrusion of the right L5 pedicle screw into the L4-5 intervertebral disc space, minimal degenerative disc disease, grade I retrolisthesis at L3-4, and narrowing of the L5-S1 intervertebral disc space. On 05/10/2013, he was seen for neurosurgical consultation. On exam, he had diminished perception to light touch in the anterior shin and lateral foot of the left lower extremity and deep tendon reflexes were absent at the left knee and ankle and 2+ on the right. He was able to heel and toe walk and could squat and stand without assistance. X-rays were reviewed demonstrating levoconvex scoliosis with a grade I spondylolisthesis of L3 on L4 with possible pseudarthrosis with misplacement of the pedicle screw. On 05/28/2013, a CT of the lumbar spine was obtained. This exam revealed post-surgical changes from laminectomies and hardware placement involving the L4 and L5 vertebrae, the left L5 screw traverses into the soft tissues, and there is probable loosening involving the proximal 1/3rd of the right L5 screw. There was also degenerative disc disease and there was a posterior disc protrusion at L3-4 with mild to moderate spinal stenosis and impingement of the left L3 nerve root at the left neural canal with impingement of the left L4 nerve root at the left lateral recess and possible impingement of the right L4 nerve root at the right lateral recess. There was suspicion for scar tissue at the L4-5 level. On 07/09/2013, he returned to neurosurgical clinic with diminished perception to light touch in the lateral shin and right lower extremity and right lower extremity strength was 4/5 in right hip flexion with 5/5 strength on the right. He had moderate to severe tenderness to palpation in the mid lumbar spine. On 07/12/2013, he returned to occupation medicine clinic. At that time, deep tendon reflexes were 2+ and his gait was normal. He had no foot drop and no weakness noted and had normal strength. He had a straight leg raise at 100 degrees on the left. On 07/23/2013, a utilization review determination was submitted indicating the requested surgery was non-certified as there was no radiological evidence of loosening of the hardware or infection noted. It was noted that the imaging studies report there was note of failure of hardware and no documentation of any specific pseudarthrosis. There was no documentation of a psych status, no documentation of smoking or nicotine status, and no flexion or extension views were provided demonstrating inability. There were no EMGs or NCVs to document clinical radiculopathy or neural compression. Therefore, the request was non-certified.

#### **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 L4-5 explore fusion:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on Low back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition, (2004), Chapter 12), pages 305-307, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints. In. Harris J (Ed), Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 307, which is part of the MTUS, and the Official Disability Guidelines, (ODG), Low Back Chapter, Surgery, which is not part of the MTUS.

Rationale for the Decision:

The ACOEM guidelines do not specifically address exploration of fusion, but the ODG Guidelines, Low Back Chapter is utilized in support of MTUS/ACOEM. The Official Disability Guidelines indicates revision surgery for purposes of pain relief must be approached with extreme caution due to less than 50% success rate reported in the medical literature. The submitted medical records indicate on the CT that a screw is going into the soft tissues and into the canal which would indicate it is a pain generator. There is questioning of loosening and/or infection as well. Previous determination dated 07/23/2013 non-certified this request indicating that there was no radiological evidence of loosening of the hardware or infection noted. However, the CT scan dated 05/28/2013 clearly demonstrates there is malpositioning of the hardware at the L4-5 level. There was also question of loosening as well. Pending this surgery for further conservative care and/or imaging studies and/or electrodiagnostic studies would not solve the issue as this is a mechanical issue with failed hardware at this point. **The request for exploration of the L4-5 fusion is medically necessary and appropriate**

**2) Regarding the request for L3-4 discectomy:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on Low back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition, (2004), Chapter 12), pages 305, 306, which is part of the MTUS.

The Expert Reviewer found the Low back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition, (2004), Chapter 12), page 306, which is part of the MTUS.

Rationale for the Decision:

The ACOEM guidelines indicate surgical intervention when there is 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 failure of conservative treatment to resolve disabling radicular symptoms. This case was previously non-certified due to lack of EMGs demonstrating radiculopathy and lack of documentation of functional limitations on the part of the patient and lack of documentation of conservative care. Medical records submitted for review indicate that the MRI does reveal at the L3-4 level, there is a suspicion for impingement of the left L5 nerve root. The physical findings on 07/09/2013 reveal right lower extremity hip flexion strength rated at 4-/5 with diminished sensation to light touch in the lateral shin and right lower extremity. The imaging studies therefore, do not correlate with physical findings as recommended by guidelines. There is also lack of documentation of significant current conservative care. **The request for L3-4 discectomy is not medically necessary and appropriate.**

**3) Regarding the request for possible fusion:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition, (2004), Chapter 12), pages 305-307, which is part of the MTUS.

The Expert Reviewer found the Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition, (2004), Chapter 12), pages 305-306, which is part of the MTUS.

Rationale for the Decision:

The request is labeled “decision for possible fusion” without documenting what level a possible fusion is to be performed at. This request was previously non-certified as there was documentation at that time that the request would include an L3-4 discectomy with possible fusion. The rationale given was that there was a lack of documentation of pathology, conservative care, and physical findings. As such, the request was non-certified. The records provided for this review do document pathology, but they are on the left side and the physical findings are on the right side. Therefore, rationale for an L3-4 discectomy has not been documented. There is no instability noted at the L3-4 level and no spondylolisthesis grade II or greater at the L3-4 level. Therefore, the medical necessity of this request has not been demonstrated. **The request for possible fusion is not medically necessary and appropriate**

**4) Regarding the request for assistant surgeon:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American Association of Orthopedic Surgeons, Position Statement Reimbursement of First Assistant at Surgery in Orthopedics, 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 American College of Surgeons, Physicians as Assistants at Surgery, 2011.

Rationale for the Decision:

An assistant surgeon may be needed if there is prolonged surgical talent, prolonged loss of anticipated increased loss of blood, or technical aspects of the case that would make an assistant surgeon medically necessary. It is necessary to explore the fusion and remove the hardware, but there is no indication there is a pseudarthrosis that would require significant increased surgical time or increased technical experience. **The request for an assistant surgeon is not medically necessary and appropriate.**

**5) Regarding the request for Aspen LSO lumbar brace:**

Rationale for the Decision:

Since the L3-4 discectomy surgery is not medically necessary, none of the associated services are medically necessary and appropriate.

**6) Regarding the request for external bone growth stimulator:**

Rationale for the Decision:

Since the L3-4 discectomy surgery is not medically necessary, 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,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> 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.