MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 12/2/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/26/2013
Date of Injury:	4/3/2013
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007109

1) MAXIMUS Federal Services, Inc. has determined the request for **inspection of fusion mass is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **possible re-grafting of pedicle screw holes is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **nerve root exploration is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **medical clearance with MD (Internist) is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the request for **two Ondansetron ODT #30 is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the request for **two Medrox pain relief ointment 120gm is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/26/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/10/2013. 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 inspection of fusion mass is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **possible re-grafting of pedicle screw holes is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **nerve root exploration is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **medical clearance with [redacted] MD (Internist) is not medically necessary and appropriate.**

5) MAXIMUS Federal Services, Inc. has determined the request for **two Ondansetron ODT #30 is not medically necessary and appropriate.**

6) MAXIMUS Federal Services, Inc. has determined the request for **two Medrox pain relief ointment 120gm 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 Neurologic 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:
49year old male who was injured on the job 2011. He has undergone "a very successful lumbar fusion at the levels of L5-S1" as noted in the 6/17/13 report. He has had some symptoms at the upper end of the hardware. As a result his surgeon would like to remove the L5-S1 hardware, inspect the fusion mass, and re graft the pedicle screws utilizing an assistant surgeon. This would require a 2 day hospital stay and medical clearance. Approval also is requested for various meds.

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:

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

1) **Regarding the request for inspection of fusion mass :**

   The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
   The Claims Administrator did not cite any evidence-based guidelines for its decision.

   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 1) Stavridis SL et al.Implant removal after posterior stabilization of the thoraco lumbar junction. ARCH ORTH TRAUMA SURG 10:402,2009, 2) Avyas A et al. Safety and efficacy of implant removal for patients with recurrent back pain after a failed degenerative lumbar spine surgery. J SP DISORD TECH 20:271,2007. 3) Haufe S et al. Surgical considerations of entire lumbar spine hardware removal via a minimally invasive approach. J SURG ORTH ADVANCES 17:82,2008, none of which are part of the MTUS.

   Rationale for the Decision:
   Inspection of the fusion mass would be performed if there is evidence of pedicle screw failure, pedicle screw fracture, pedicle screw loosening, infection, or fracture at the operative site. A review of the records indicated that none of these were noted, so there would not have been any reason to remove the hardware.There are no large, long term, scientific, randomized, prospective studies supporting the removal of fusion hardware for continued subjective pain. There are a number of small (57 patients;25 patients;13 patients), retrospective, short term studies (Stavridis;Avyas;Haufe) which lack scientific merit.
   Since there was no medical data to note pedicle screw failure, pedicle screw fracture, pedicle screw loosening, instability, infection, non union ,mechanical pain, nor pseudarthrosis there would be no indication to inspect the fusion mass.
   The request for inspection of fusion mass

2) **Regarding the request for possible re-grafting of pedicle screw holes:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

3) **Regarding the request for nerve root exploration :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator did not cite any evidence-based guidelines for its decision.

The Expert Reviewer based his/her decision on Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 305, Surgical considerations, which is a part of the MTUS and Milliman Care Guidelines 17th ed. Lumbar discectomy,foraminotomy, laminotomy and Milliman care Guidelines 17th ed. Neurosurgery or Procedure GRG, which is not a part of the MTUS.

Rationale for the Decision:
Surgical exploration is performed when there is evidence of radiculopathy "with accompanying objective signs of neural compromise"(ACOEM). A review of the records indicates that the employee has no sx/signs of radiculopathy nor objective signs of neural compromise. Milliman Guidelines also note surgery for radiculopathy for disc herniation,stenosis with neurogenic claudication, nerve defecit, fracture, infection amongst other criteria. None of these have been met. **The request for nerve root exploration**

4) **Regarding the request for medical clearance with [redacted] MD (Internist) :**

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

5) **Regarding the request for two Ondansetron ODT #30 :**

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

6) **Regarding the request for two Medrox pain relief ointment 120gm:**

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

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: [redacted]

/pr

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.