

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/15/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	11/3/2006
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0009904

- 1) MAXIMUS Federal Services, Inc. has determined the request for L4-L5 and L5-S1 Anterior Lumbar Interbody Fusion with Cage and Allograft **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Bilateral L4-L5 and L5-S1 Decompression and L4-L5 and L5-S1 Posterolateral Fusion with Screws and Allograft **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 7/22/2013. 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 L4-L5 and L5-S1 Anterior Lumbar Interbody Fusion with Cage and Allograft **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Bilateral L4-L5 and L5-S1 Decompression and L4-L5 and L5-S1 Posterolateral Fusion with Screws and Allograft **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.

Expert Reviewer Case Summary:

This claimant is a 60-year-old female with a reported date of injury of 11/03/2006. Reported mechanism of injury was described as walking while pushing a cart doing her regular job duties as a laborer, and she slipped and fell backwards landing on her back and developing immediate pain to her left leg, low back, left shoulder and left knee. Initial orthopedic exam revealed excellent lower extremity sensation with no weakness or atrophy involving the lower extremities following a dermatomal pattern. Reflexes were 1+ and symmetrical at the patellae and Achilles region and there were no pathological reflexes noted. The patient is noted to have undergone x-rays of the lumbar spine and MRI of the lumbar spine in the past. The most recent plain x-rays on 04/11/2013 revealed mild discogenic spondylosis at L5-S1, mild degenerative facet joint arthrosis at L4 to S1 and mild left lumbar convexity. The recent MRI revealed a ventral and right-sided disc protrusion at L5-S1 resulting in mild canal and moderate right and mild to moderate left foraminal stenosis and mild to moderate canal and bilateral foraminal stenosis at L4-5. The most recent physical exam revealed straight leg raise maneuver was positive with decreased sensation in the right L4, L5 and S1 dermatomes and the left L5 dermatome showed some decreased sensation. Diagnoses include discogenic pain at L4-L5 to the right and L4-L5 spondylolisthesis. Treatment plan included L4-L5 and L5-S1 Anterior Lumbar Interbody Fusion with Cage and Allograft and Bilateral L4-L5 and L5-S1 Decompression and L4-L5 and L5-S1 Posterolateral Fusion with Screws and Allograft.

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-L5 and L5-S 1 Anterior Lumbar Interbody Fusion with Cage and Allograft:

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 College of Occupational and Environmental Medicine, Chapter 12, pg 305-307, which is a part of the MTUS.

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

Rationale for the Decision:

The California MTUS/ACOEM, Low Back Chapter, indicates for surgical consideration, there should be “severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies” preferably with accompanying objective signs and neural compromise. There should also be “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. The guidelines further state there should be “failure of conservative treatment to resolve disabling radicular symptoms.” Specifically, for a lumbar surgical interventions, the guidelines indicate that “before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes.” The submitted medical records indicate that the employee had an MRI dated 10/25/2012 which revealed a ventral and right-sided disc protrusion at L5-S1, resulting in mild canal and moderate right and mild to moderate left-sided foraminal stenosis. There was also mild to moderate canal and bilateral foraminal stenosis at L4-5. There was no indication that there was instability on that MRI scan. Plain x-rays performed on 04/11/2013 revealed mild discogenic spondylosis at L5-S1, mild degenerative facet joint arthrosis at L4 to S1. The last clinical exam does reveal that straight leg raise is positive but does not indicate whether this is left-sided or right-sided or whether it produces back pain or true radicular pain. That clinical exam also indicates there is decreased sensation in the right L4, L5 and S1 dermatome and the left L5 dermatome shows some decreased sensation. There is no current EMG provided for this review to objectively document sensory deficits. There is no indication on the last clinical note that the employee has other functional deficits such as reflex changes or significant motor deficits. The guidelines recommend a psychological evaluation and there should be failure of conservative treatment to resolve disabling

radicular symptoms. Although the employee has had epidural steroid injections, and the records discuss physical therapy, no current physical therapy notes were provided for this review to objectively document failure of conservative measures in that format and there is no documentation provided of a psychological evaluation. **The request for Error! Reference source not found. is not medically necessary and appropriate.**

2) Regarding the request for Bilateral L4-L5 and L5-S1 Decompression and L4-L5 and L5-S1 Posterolateral Fusion with Screws and Allograft:

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 College of Occupational and Environmental Medicine, Chapter 12, pg 305-307, which is a part of the MTUS.

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

Rationale for the Decision:

An MRI dated 10/25/2012 does reveal ventral and right-sided disc protrusion at L5-S1 resulting in mild canal and moderate right and mild to moderate left-sided foraminal stenosis. There is also mild to moderate canal and bilateral foraminal stenosis at L4-5. Plain x-rays, however, on 04/11/2013 reveal mild discogenic spondylosis at L5-S1 and mild degenerative facet joint arthrosis at L4 to S1. The most recent clinical exam does indicate that there is some decreased sensation in a right L4, L5 and S1 dermatome and the left L5 dermatome showed some decreased sensation but this is subjectively documented and there is no current EMG to document sensory deficits in a specific neural pattern. The submitted and reviewed records do not indicate whether the straight leg raise produces only back pain or true radicular pain and the records do not indicate which side it is on. The California MTUS/ACOEM, Low Back Chapter, indicates that there should be “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 there should be “failure of conservative treatment to resolve disabling radicular symptoms.” For surgical intervention to the lumbar spine the guidelines advocate referral for psychological screening to improve surgical outcomes. The records do not indicate there has been a current psychological screen performed for this employee. The records indicate there is only mild facet disease and there is no instability noted and no pars defect noted on imaging studies. However, the records do not demonstrate the rationale for proceeding with bilateral L4-5 and L5-S1 decompression and L4-5 and L5-S1 posterolateral fusion with screws and allograft. The records reviewed lack physical therapy notes indicating a failure of current conservative measures, there were no electrodiagnostic studies confirming radiculopathy, and no documented psychosocial evaluation. **The request for Bilateral L4-L5 and L5-S1 Decompression and L4-L5 and L5-S1 Posterolateral Fusion with Screws and Allograft 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,

Paul Manchester, MD, MPH
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.