

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
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Notice of Independent Medical Review Determination

Dated: 10/25/2013

[Redacted]

[Redacted]

Employee: [Redacted]
Claim Number: [Redacted]
Date of UR Decision: 7/16/2013
Date of Injury: 11/12/2008
IMR Application Received: 7/24/2013
MAXIMUS Case Number: CM13-0002996

- 1) MAXIMUS Federal Services, Inc. has determined the request for L4-5 artificial disc replacement **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for total disc arthroplasty **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for L5-S1 anterior 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 3-4 day in patient stay **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for pre-op history and physical with chest xray **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for labs **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for CBC **is not medically necessary and appropriate.**

- 9) MAXIMUS Federal Services, Inc. has determined the request for CP13 **is not medically necessary and appropriate.**
- 10) MAXIMUS Federal Services, Inc. has determined the request for UA **is not medically necessary and appropriate.**
- 11) MAXIMUS Federal Services, Inc. has determined the request for 1 unit blood donation **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 artificial disc replacement **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for total disc arthroplasty **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for L5-S1 anterior 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 3-4 day in patient stay **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for pre-op history and physical with chest xray **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for labs **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for CBC **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for CP13 **is not medically necessary and appropriate.**
- 10) MAXIMUS Federal Services, Inc. has determined the request for UA **is not medically necessary and appropriate.**
- 11) MAXIMUS Federal Services, Inc. has determined the request for 1 unit blood donation **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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 16, 2013:

According to the records made available for review, this is a 34-year-old male patient, s/p injury 11/12/08. The patient most recently (6/3/13) presented with lumbar pain with left lower extremity radiculopathy. Physical examination revealed slight left thigh weakness 5-/5, slight left EHL weakness 5-/5, left SSLR positive for LLE pulling. Reported MRI L/S (10/5/11) revealed loss of lordosis as well as moderate to severe desiccation and mild to moderate disc space narrowing at L4-L5 and L5-S1 with protrusions, moderate central stenosis, severe lateral recess, and bilateral foraminal stenosis: L5-S1 with central protrusion eccentric to the right, creating moderate central stenosis and right greater than left lateral recess and foraminal stenosis, and protrusion abutting the left L5 nerve; report not available for review. 6/27/13 Appeal letter identifies that the patient has shown complete compliance with the recommended psychological evaluation and treatment. Current diagnoses include lumbar sprain with lower extremity radiculopathy and instability. Treatment to date includes medication, PT, ESI, and psych evaluation. Treatment requested is L4-5 artificial disc replacement, total disc arthroplasty, and L5-S1 anterior fusion, assistant surgeon, 3-4 day inpatient stay, pre-op history and physical with chest x-ray, labs, CBC, CP13, UA, and 1 unit blood donation.

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 (receive 07/24/2013)
- Utilization Review Determination from [REDACTED] (dated 07/16/2013)
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for L4-5 artificial disc replacement : 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 (ACOEM) guidelines, section not cited, pages 305-306, part of the MTUS, and the Official Disability Guidelines (ODG), (Current Version), Low Back Chapter, a medical treatment guideline, not part of the MTUS. The Expert Reviewer found the Low Back Complaints, (ACOEM Practice Guidelines, 2nd Edition, 2004, Chapter 12),

Surgical Considerations, pages 305-306), part of the MTUS, and the Official Disability Guidelines (ODG), (Current Version), Low Back Section, Disc Prosthesis, not part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the low back in an industrially related accident on 11/12/2008. According to the submitted and reviewed records the employee has had medications, physical therapy, epidural steroid injections, and psychological treatment. The records indicated that the employee has shown compliance with recommended psychological evaluation and treatment. Current diagnoses included lumbar sprain with lower extremity radiculopathy and instability. A request was submitted for L4-5 artificial disc replacement, total disc arthroplasty, L5-S1 anterior fusion, assistant surgeon, 3-4 day inpatient stay, pre-op history and physical with chest x-ray, labs, CBC, CP13, UA, and 1 unit of blood donation.

MTUS/ACOEM Guidelines indicate that there should be, clear clinical and electrophysiological evidence of a lesion that has been shown to benefit from both short and long-term surgical repair and documentation of failure of conservative treatment to resolve disabling radicular symptoms. The Official Disability guidelines indicate disc replacement is not recommended. Studies have failed to demonstrate superiority of disc replacement over lumbar fusion. The clinical notes reviewed fail to describe a complete objective neurological or orthopedic exam and the imaging studies were not provided for this review. Furthermore, there is lack of documentation of significant current conservative care or physical therapy notes, and interventional injection notes were not provided for this review. The request for L4-5 artificial disc replacement **is not medically necessary and appropriate.**

2) Regarding the request for total disc arthroplasty :
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 (ACOEM), section not cited, pages 305-306, part of the MTUS. The Expert Reviewer found the Low Back Complaints, (ACOEM Practice Guidelines, 2nd Edition, 2004, Chapter 12), Surgical Considerations, pages 305-306, part of the MTUS, and the Official Disability Guidelines (ODG), (Current Version), Low Back Section, Disc Prosthesis, a medial treatment guideline, not part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the low back in an industrially related accident on 11/12/2008. According to the submitted and reviewed records the employee has had medications, physical therapy, epidural steroid injections, and psychological treatment. The records indicated that the employee has shown compliance with recommended psychological evaluation and treatment. Current diagnoses included lumbar sprain with lower extremity radiculopathy and instability. A request was submitted for L4-5 artificial disc replacement, total disc arthroplasty, L5-S1 anterior fusion, assistant surgeon, 3-4 day inpatient stay, pre-op history

and physical with chest x-ray, labs, CBC, CP13, UA, and 1 unit of blood donation.

MTUS/ACOEM Guidelines indicate that there should be, clear clinical and electrophysiological evidence of a lesion that has been shown to benefit from both short and long-term surgical repair and documentation of failure of conservative treatment to resolve disabling radicular symptoms. The Official Disability Guidelines indicate disc replacement is not recommended. Studies have failed to demonstrate superiority of disc replacement over lumbar fusion. The clinical notes reviewed fail to describe a complete objective neurological or orthopedic exam and the imaging studies were not provided for this review. Furthermore, there is lack of documentation of significant current conservative care or physical therapy notes, and interventional injection notes were not provided for this review. The request for total disc arthroplasty **is not medically necessary and appropriate.**

3) Regarding the request for L5-S1 anterior 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 the American College of Occupational and Environmental Medicine (ACOEM), section not cited, pages 305-306, part of the MTUS. The Expert Reviewer found the Low Back Complaints, (ACOEM Practice Guidelines, 2nd Edition, 2004, Chapter 12), Surgical Considerations, pages 305-306, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the low back in an industrially related accident on 11/12/2008. According to the submitted and reviewed records the employee has had medications, physical therapy, epidural steroid injections, and psychological treatment. The records indicated that the employee has shown compliance with recommended psychological evaluation and treatment. Current diagnoses included lumbar sprain with lower extremity radiculopathy and instability. A request was submitted for L4-5 artificial disc replacement, total disc arthroplasty, L5-S1 anterior fusion, assistant surgeon, 3-4 day inpatient stay, pre-op history and physical with chest x-ray, labs, CBC, CP13, UA, and 1 unit of blood donation.

MTUS/ACOEM Guidelines indicate that a psychosocial evaluation should be performed prior to undergoing this intervention and there should be documentation of clear clinical imaging and electrophysiological evidence of a lesion that has been shown to benefit in both short and long-term from surgical repair and documentation of conservative care to resolve disabling radicular symptoms. No significant conservative care has been documented and interventional injection notes were not provided for this review. A psychological evaluation and imaging studies were not provided for this review. The request for L5-S1 anterior fusion **is not medically necessary and appropriate.**

4) Regarding the request for assistant surgeon :

Since the procedures in 1, 2, & 3 are not medically necessary, none of the associated requests are medically necessary and appropriate.

5) Regarding the request for 3-4 day in patient stay :

Since the procedures in 1, 2, & 3 are not medically necessary, none of the associated requests are medically necessary and appropriate.

6) Regarding the request for pre-op history and physical with chest xray :

Since the procedures in 1, 2, & 3 are not medically necessary, none of the associated requests are medically necessary and appropriate.

7) Regarding the request for labs :

Since the procedures in 1, 2, & 3 are not medically necessary, none of the associated requests are medically necessary and appropriate.

8) Regarding the request for CBC :

Since the procedures in 1, 2, & 3 are not medically necessary, none of the associated requests are medically necessary and appropriate.

9) Regarding the request for CP13 :

Since the procedures in 1, 2, & 3 are not medically necessary, none of the associated requests are medically necessary and appropriate.

10) Regarding the request for UA :

Since the procedures in 1, 2, & 3 are not medically necessary, none of the associated requests are medically necessary and appropriate.

11) Regarding the request for 1 unit blood donation :

Since the procedures in 1, 2, & 3 are not medically necessary, none of the associated requests 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.