

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 10/29/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/17/2013
Date of Injury:	1/26/2009
IMR Application Received:	10/25/2013
MAXIMUS Case Number:	CM13-0030944

- 1) MAXIMUS Federal Services, Inc. has determined the request for an L3-4 and L4-5 decompression, posterolateral instrumental fusion with possible transforaminal lumbar interbody fusion and bone graft, cages and posterolateral segmental instrumentation **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 10/25/2013 disputing the Utilization Review Denial dated 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/25/2013. 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 an L3-4 and L4-5 decompression, posterolateral instrumental fusion with possible transforaminal lumbar interbody fusion and bone graft, cages and posterolateral segmental instrumentation **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:

The patient is a 46 year-old male with low back pain, with a date of injury of 1/26/09. An MRI of the lumbar spine dated 1/27/13 demonstrates disc degeneration at L3/4 and L4/5 with 3 mm disc protrusion and no central canal stenosis. The reviewed upright radiographs demonstrate no instability on 1/27/13. The records indicate normal neurologic exam with restricted range of motion lumbar spine. The request is for two level lumbar fusion L3/4 and L4/5.

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, employee/employee representative, Provider)
- Medical Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request for an L3-4 and L4-5 decompression, posterolateral instrumental fusion with possible transforaminal lumbar interbody fusion and bone graft, cages and posterolateral segmental instrumentation:**

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, California Medical Treatment and Utilization Schedule Plus, Online Version, Low Back Complaints, Surgical Considerations, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), Spinal Fusion, pg. 307, which is part of the MTUS, the Official Disability Guidelines (ODG), Low Back Chapter, Fusion (spinal), Brox JL, Nygaard OP, Holm I, Keller A, Ingebrigtsen T, Reikeras O. Four-year followup of surgical versus non-surgical therapy for chronic low back pain. Ann Rheum Dis 2010 Sep; 69(9):1643-8 Epub 2009 July 26., Chou, R, Baisden, J., Carragee, E., Resnick, D., Shaffer, W. Loeser, J. Surgery for Low Back Pain: A Review of the Evidence for an American Pain Society Clinical Practice Guideline. Spine 2009 May; 34(10):1094-1109., Deyo RA, Nachemson A, Mirza SK, Spinal-fusion surgery - the case for restraint, N Engl J Med. 2004 Feb 12;350(7): 722-6., and Deyo RA, Gray DT, Kreuter W, Mirza S, Martin BI. United States trends in lumbar fusion surgery for degenerative conditions. Spine. 2005 Jun 15;30(12): 1441-5; discussion 1446-7., which are not part of the MTUS.

Rationale for the Decision:

MTUS ACOEM guidelines state, "there is no scientific evidence about the long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylolysis compared with natural history, placebo or conservative treatment." Fusion for lumbar disc degeneration has been shown to be no better than non-surgical therapy for chronic low back pain. This has been supported by high quality systematic reviews in the medical literature. In the records submitted for review there is no evidence of severe disabling radiculopathy, progressive neurologic findings or clinical evidence of significant nerve root compromise. In addition, there is no evidence of instability in the lumbar spine to warrant a lumbar fusion and no evidence of anterior spondylolisthesis. Lumbar fusion in this case only increases the risk of further adjacent segment disease and need for further surgical procedures in the future. **The request for an L3-4 and L4-5 decompression, posterolateral instrumental fusion with possible transforaminal lumbar interbody fusion and bone graft, cages and posterolateral segmental instrumentation 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,

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

/lkh

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.