

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

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the request for Surgery for T12-L2 Posterior Decompression fusion and instrumentation, allograft, assistant surgeon, and pre-op **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Inpatient Hospital length of stay (LOS) for three and one half days **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/14/2013 disputing the Utilization Review Denial dated 5/28/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/17/2013. 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 T12-L2 Posterior Decompression fusion and instrumentation, allograft, assistant surgeon, and pre-op requested **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Inpatient Hospital length of stay (LOS) for three and one half days **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 May 28, 2013

"The claimant was injured when the ladder the claimant was on went out from under the claimant and the claimant fell, Injuring the low back. MR.I dated 04/04/13 notes at T12• L1 there is a posterior osseous retropulsion that indents the vent111l thecal sac with flattening of the conus resulting in spinal canal stenosis. There is an acute comminuted type burst fracture of L1 with 40% loss of the vertebral body height and posterior osseous retropulsion. There is mild facet arthropathy noted at L1•L2 with thickening of the ligamentum flavum. There is mild bilateral neural foramina! stenosis at L4-L5. The claimant presented on 05/08/13 with complaints of abdominal pain, mid and low back pain as well as bilateral hip pain and light upper leg pain. The claimant has been treated with medications, physical therapy, and a Velcro brace. Exam notes trigger points, hyperlordosis, and spasm in the lumbar spine. Foramina compression testing was positive on the right and straight leg raise is positive on the right. There is general muscle weakness due to pain on the right. Range of motion is reduced. The provider recommends a posterior decompression and fusion at T12-L2."

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 dated 6/14/2013

- Utilization Review recommendation provided by [REDACTED] dated 5/28/2013
- Submitted Medical records from 3/13/2013 through 6/18/2013
- American College of Occupational and Environmental Medicine Guidelines, 2nd Edition, 2004, Low Back Complaints, Surgical Considerations pages 305-307
- Official Disability Guidelines (ODG) 2009, Low Back Section, Hospital Length of Stay (LOS)

1) Regarding the request for surgery for T12-L2 posterior decompression fusion and instrumentation, allograft, assistant surgeon, and pre-op:

Medical Treatment Guideline(s) 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, 2nd Edition, 2004, Low Back Complaints, Surgical Considerations pg. 305-307, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured in a work-related accident on 3/13/2013 after falling from a ladder. Medical records provided and reviewed indicate initial treatment in the emergency department where a CT scan and x-rays were taken. Further treatment consisted of rest, pain medications, physical therapy, chiropractic treatment, a Velcro brace, and a MRI demonstrating L1 burst fracture with a loss of 40% vertebral body height, bulging of the posterior cortex, and 3.5 mm posterior osseous retropulsion. Referral was made to a spine specialist. The medical record from May 8, 2013 documents moderate bilateral back pain with frequent aching, and surgery was requested for a T12-L2 posterior decompression fusion.

ACOEM Guidelines allow for lumbar fusion when all pain generators are adequately defined and treated; all physical medicine and manual therapy interventions are completed; X-ray MRI or CT/discography demonstrate disc pathology or spinal instability; spine pathology is limited to two levels; and psychosocial evaluation with confounding issues addressed. The medical records reviewed show insufficient evidence of a progressive neurologic deficit to warrant a surgical fusion for a four-month old L1 burst fracture. Surgery for T12-L2 posterior decompression fusion and instrumentation, allograft, assistant surgeon, and pre-op **is not medically necessary and appropriate.**

2) Regarding the request for inpatient hospital stay for three and one half days:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) 2009, Low Back Section, Hospital Length of Stay (LOS), which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the MTUS did not address the issue at dispute and agreed the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured in a work-related accident on 3/13/2013 after falling from a ladder. Medical records provided and reviewed indicate initial treatment in the emergency where a CT scan and x-rays were taken. Further treatment consisted of rest, pain medications, physical therapy, chiropractic treatment, a Velcro brace, and a MRI demonstrating L1 burst fracture with a loss of 40% vertebral body height, bulging of the posterior cortex, and 3.5 mm posterior osseous retropulsion. Referral was made to a spine specialist. The medical record from May 8, 2013, documents moderate bilateral back pain with frequent aching, and indicates surgery was requested for a T12-L2 posterior decompression fusion.

ODG Guidelines do allow for a three-day hospital stay for lumbar fusion, however, based on the criteria for lumbar fusion not being met, the issue of the inpatient hospital stay would not be relevant. The inpatient hospital stay for three and one half days **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

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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.