

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/4/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/1/2013  
Date of Injury: 6/21/2012  
IMR Application Received: 7/26/2013  
MAXIMUS Case Number: CM13-0003677

- 1) MAXIMUS Federal Services, Inc. has determined the request for neural decompression **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for iliac crest marrow aspiration/harvesting **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for possible junctional levels **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for three (3) days inpatient stay **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for assistant surgeon **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for L4-S1 possible L2-S1 posterior lumbar interbody fusion with instrumentation **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for Medrox pain relief ointment 120gm times two (2) **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for Tramadol Hydrochloride extended release capsules 150mg #90 **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/1/2013. 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 neural decompression **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for iliac crest marrow aspiration/harvesting **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for possible junctional levels **is not medically necessary and appropriate.**
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- 7) MAXIMUS Federal Services, Inc. has determined the request for Medrox pain relief ointment 120gm times two (2) **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for Tramadol Hydrochloride extended release capsules 150mg #90 **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 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's Case Summary:**

The patient was reportedly injured on 6/21/2012. On 8/29/2012, the patient was seen in clinic. At that time, he had complaints of being injured when he stepped onto a stool to wash the top a car, when he struck his head on a piece of overhead pipe, causing him to fall backwards, landing on his back. He states he is continuing to experience low back pain. He denies previous surgeries. On physical examination, he stands 5 feet 3 inches tall and weighs 160 pounds. X-rays of the lumbar spine demonstrated significant spondylosis and almost complete disc space height collapse and bone on bone erosion at the levels of L4-5 and L5-S1 with generalized multiple spondylosis noted throughout the entire lumbar spine. On 1/30/2013, the provider noted continued tenderness to the mid to distal lumbar segments with pain with terminal motion, seated test was positive, and he had dysthesias at the L5-S1 dermatomes. He was continued on medications at that time. He returned to clinic on 5/22/2013 for further evaluation. A surgical procedure was discussed with him at that time and he had a physical exam which revealed motor strength to be no greater than 3+/5. The patient admitted to dragging his feet and giving way of his legs, consistent with foot drop.

### **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 7/26/13)
- Utilization Review Determination from [REDACTED] (dated 7/1/13)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for neural decompression :**

##### 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 Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12), pages 305-307, which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Low Back, Discectomy/Laminectomy section. The Expert Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

##### Rationale for the Decision:

The ACOEM Guidelines indicate 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." Further, the guidelines state that there should be "failure of conservative treatment to resolve disabling radicular symptoms." The records provided for this review do not include physical therapy notes and/or individual injection notes to provide objective evidence that the employee has failed conservative measures. The records do not include imaging studies and/or electrodiagnostic studies to confirm pathology in the lumbar spine that would warrant this level of surgical intervention. Segmental instability was

noted with documented specific levels. **The requested neural decompression is not medically necessary and appropriate.**

**2) Regarding the request for iliac crest marrow aspiration/harvesting :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter. 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 the following article: Hustedt, J., et al. Optimal Aspiration Volume of Vertebral Bone Marrow for Use in Spinal Fusion. Spine J, 2013 Sep 25. pii: S1529-9430(13)01270-9.

Rationale for the Decision:

The article cited above notes that, "Bone marrow aspirate (BMA) has shown promise as a bone graft option in spinal fusion. The vertebral body is a convenient source for marrow aspirate as it is accessed in routine course of pedicle screw instrumentation. Studies have relied on data from the iliac crest to determine optimal aspiration volume from the vertebral body." These findings suggest the procedure holds promise but is not considered the standard care at this time. **The requested iliac crest marrow aspiration/harvesting is not medically necessary and appropriate.**

**3) Regarding the request for possible junctional levels:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter. The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition, 2004, Low Back, page 307, which is part of the MTUS.

Rationale for the Decision:

The ACOEM state that spinal fusion except for cases of trauma related spinal fracture or dislocation is not usually considered during the first three months of symptoms. In addition, patients with increased spinal instability (not work related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. Further, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. The guidelines also indicate that psychosocial evaluation should be performed prior to undergoing this level of surgical intervention. The requested treatment is for possible junction levels but the request does not state whether the junction

levels will be fused, decompressed, or just simply weighted. Surgical intervention in the form of neural decompression is not medically indicated due to the fact that there is lack of documentation of significant current conservative care and lack evidence of the specific anatomic site for requested for the surgical procedure. The employee's psychosocial evaluation was also not provided for review. **The requested possible junctional levels is not medically necessary and appropriate.**

**4) Regarding the request for three (3) days inpatient stay :**

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 Official Disability Guidelines (ODG), Low Back Chapter, Hospital Length of Stay section, which is not part of the MTUS. 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 the referenced section of the ODG used by the Claims Administrator.

Rationale for the Decision:

The ODG indicates that 3 days would be considered reasonable for a lumbar fusion, should it take place. However, the records submitted and reviewed do not support the indication for the requested surgery which would necessitate the inpatient stay. **The requested three (3) days inpatient stay is not medically necessary and appropriate.**

**5) Regarding the request for assistant surgeon:**

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 Association of Orthopaedics Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics, Role of the First Assistant section, which is not part of the MTUS. 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 the criteria used by the Claims Administrator.

Rationale for the Decision:

The American College of Surgeons indicate in general, the more complex and risky the operation, the more highly trained the physician should be. Criteria include documentation of anticipated blood loss, anticipated anesthesia, anticipated instance of intraoperative complications, and/or anticipated fatigue factors affecting the surgeon and other members of the operating team. The requested surgery is not supported as medically necessary. **The request for an assistant surgeon is not medically necessary and appropriate.**

**6) Regarding the request for L4-S1 possible L2-S1 posterior lumbar interbody fusion with 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 MTUS Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12), pages 305-307, and also cited the Official Disability Guidelines (ODG), Low Back Chapter, Fusion section. The Expert Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The ACOEM indicates that there should be documentation of a psychosocial evaluation prior to undergoing a surgical measure, and there should be documentation of clear clinical and imaging electrophysiologic evidence of a lesion that has been shown to benefit both in the short and long term from surgical repair. The records provided for review did not include an imaging study or an electrodiagnostic study. There is also a lack of documentation of conservative care and or presence of instability. Additionally, the specific anatomic site of fusion should be determined prior to the surgical procedure.

**The requested L4-S1 possible L2-S1 posterior lumbar interbody fusion with instrumentation is not medically necessary and appropriate.**

**7) Regarding the request for Medrox pain relief ointment 120gm times two (2):**

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 Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, (2009), Capsaicin and Salicylate Topicals sections, which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Pain Chapter, Compound Drugs section. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 111-113, which are part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate the requested medication is a combination of methyl salicylate and capsaicin. The guidelines state that this type of drug is largely experimental in use with few randomized control trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when other trials of antidepressants and anticonvulsants have failed and are applied locally to painful areas. However, guidelines further indicate that any compounded product that contains at least one drug or drug class is not recommended and this list includes capsaicin. The requested medication includes capsaicin. Capsaicin is rated only as an option for patients who have not responded or are intolerant to their treatments. The records provided for review do not indicate the employee has been intolerant or has failed other

treatments. **The requested Medrox pain relief ointment 120gm times two (2) is not medically necessary and appropriate.**

**8) Regarding the request for Tramadol Hydrochloride extended release capsules 150mg #90:**

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 Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, (2009), pages 93-94, which are part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 78, 82 and 113, which are part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate that this medication is well-known as an opiate-type medication and the 4 A's should be monitored. This would include monitoring for analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. Analgesia has not been objectively documented, as the employee's pain score was not noted in the records. As such, rationale for this medication is not provided for this review. **The requested Tramadol Hydrochloride extended release capsules 150mg #90 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, 18<sup>th</sup> 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.