

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: 11/18/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/18/2013
Date of Injury:	9/12/2000
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004062

- 1) MAXIMUS Federal Services, Inc. has determined the request for one (1) posterior spinal revision & decompression at L3-4 w/extreme lateral interbody approach at L3-4 for intradiscal cage placement **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 24 home health care/aid visits three (3) to four (4) times four (4) to six (6) [REDACTED] **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/6/2013. 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 one (1) posterior spinal revision & decompression at L3-4 w/extreme lateral interbody approach at L3-4 for intradiscal cage placement is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for 24 home health care/aid visits three (3) to four (4) times four (4) to six (6) ([REDACTED]) **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 Physical Medicine and Rehabilitation, 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 62-year-old male with a date of injury of 9/12/2000. The patient has been treated for chronic low back pain. History includes multiply lumbar spinal surgeries with pseudarthrosis at L3-4 and a previous spinal fusion attempt at L2-S1. Clinical examination and imaging studies indicate radiculopathy, retrolisthesis and L4 foraminal stenosis. The patient has not benefited from conservative care. The available records show no clear indication for the causation of pain, or instability in the spine of a significant nature.

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 were received, but not submitted timely by Claim Administrator
- Medical Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request for one (1) posterior spinal revision & decompression at L3-4 w/extreme lateral interbody approach at L3-4 for intradiscal cage placement:**

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 ACOEM guidelines, Chapter 12, Low Back Complaints, 2004, pg. 307 and Table 12-8, which are part of the MTUS.

The Expert Reviewer based his/her decision on the the Official Disability Guidelines (ODG), (online edition), Low Back Problems Chapter, Adjacent segment disease/degeneration (fusion) and Fusion (spinal) sections and Tosteson AN, Tosteson TD, Lurie JD, Abdu W, Herkowitz H, Andersson G, Albert T, Bridwell K, Zhao W, Grove MR, Weinstein MC, Weinstein JN. Comparative effectiveness evidence from the spine patient outcomes research trial: surgical versus nonoperative care for spinal stenosis, degenerative spondylolisthesis, and intervertebral disc herniation. *Spine (Phila Pa 1976)*. 2011 Nov 15;36(24):2061-8, which are not part of the MTUS.

Rationale for the Decision:

Evidence-based research indicates good value for surgery compared with nonoperative care over a four year period for spinal stenosis, degenerative spondylothisthesis and intervertebral disc herniation, appearing to provide a justification of the requested surgery. However, the literature is replete with findings that surgery is not indicated and condemns spinal surgery for Workers' Compensation related issues, specifically spinal fusion.

The guidelines define adjacent segment disease as the development of new clinical symptoms that correspond to radiographic changes adjacent to the level of a previous spinal fusion. The guidelines note it is unclear as to whether the radiographic and clinical findings are the result of the spinal fusion, a progression of naturally occurring degenerative disease, or both of these factors. Surgical treatment in this condition has shown limited success in providing pain relief or increased function. After a review of the medical records submitted it is a reasonable medical probability that the employee will not be improved in any significant way by this surgery. There is no indication the requested surgery is emergent. **The request for one (1) posterior spinal revision & decompression at L3-4 w/extreme lateral interbody approach at L3-4 for intradiscal cage placement is not medically necessary and appropriate.**

- 2) **Regarding the request for 24 home health care/aid visits three (3) to four (4) times four (4) to six (6) () :**

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

Since the primary procedure is not medically necessary, none of the associated services are medically necessary

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

/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.

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1021 South Meridian Avenue
Alhambra, CA 91803

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