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**Notice of Independent Medical Review Determination**

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/31/2013  
Date of Injury: 8/9/2006  
IMR Application Received: 8/14/2013  
MAXIMUS Case Number: CM13-0010693

- 1) MAXIMUS Federal Services, Inc. has determined the request for **anterior posterior decompression and fusion L5-S1 with instrumentation and bone graft by vascular surgeon is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **four (4) day inpatient stay is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **TLSO brace is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **cold therapy unit is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **bone growth stimulator is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **3:1 commode is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **front wheeled walker is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/14/2013 disputing the Utilization Review Denial dated 7/31/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/25/2013. 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 **anterior posterior decompression and fusion L5-S1 with instrumentation and bone graft by vascular surgeon** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **four (4) day inpatient stay** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **TLSO brace** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **cold therapy unit** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **bone growth stimulator** is not **medically necessary and appropriate**.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **3:1 commode** is not **medically necessary and appropriate**.
- 7) MAXIMUS Federal Services, Inc. has determined the request for **front wheeled walker** 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 Internal Medicine, and is licensed to practice in New Hampshire, New York, Washington. 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:**

This a 53 year old patient who has had back pain symptoms since 2006 and had had recent symptoms of bilateral leg and buttock pain. He has some sensory changes on physical exam in the L5 and S1 distributions. He has a lumbar mri from 2012 that demonstrates L5-S1 degenerative disk condition with an 8 mm central disk protrusion. He has tried multiple conservative measures to include PT and meds. At issue is whether or not anterior L5-S1 decompression and fusion surgery is medically necessary.

Lumbar fusion surgery is not medically necessary in this patient who has L5-S1 disk degeneration and an 8mm disk protrusion. There is no documented evidence of lumbar

instability, fracture, or concern for tumor. Fusion surgery in this patient is not more likely than nonoperative measures to relieve the patient's back pain symptoms. Current peer-reviewed literature cited below does not support the role of fusion surgery over conservative measures for the relief of back pain in patients with disc degeneration. While fusion surgery is not medically necessary, this patient is a candidate for a limited posterior L5-S1 decompression surgery only for symptoms of L5-S1 spinal stenosis. The patient has documented sensory changes in both dermatomes and has not responded to conservative measures for spinal stenosis.

#### **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
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for anterior posterior decompression and fusion L5-S1 with instrumentation and bone graft by vascular surgeon :**

##### The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on ACOEM Guidelines (text, pages 305-306), which is a part of the MTUS. The Claims Administrator also based its decision on the Official Disability Guidelines (ODG, Low Back Chapter) and the on the AMA Guidelines, 5<sup>th</sup> Edition pg. 382-383, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12) pg 307, Spinal Fusion.

##### Rationale for the Decision:

A review of the records indicates that this employee has had back pain symptoms since 2006 and had had recent symptoms of bilateral leg and buttock pain. The employee has some sensory changes on physical exam in the L5 and S1 distributions. The employee has a lumbar MRI from 2012 that demonstrates L5-S1 degenerative disk condition with an 8 mm central disk protrusion. Multiple conservative measures to include physical therapy and medications have been tried. At issue is whether or not anterior L5-S1 decompression and fusion surgery is medically necessary.

Lumbar fusion surgery is not medically necessary in this employee who has L5-S1 disk degeneration and an 8mm disk protrusion. There is no documented evidence of lumbar instability, fracture, or concern for tumor. Fusion surgery in this employee is not more likely than nonoperative measures to relieve the employee's back pain symptoms. **The request for anterior posterior decompression and fusion L5-S1 with instrumentation and bone graft by a vascular surgeon is not medically necessary and appropriate.**

**2) Regarding the request for four (4) day inpatient stay :**

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

**3) Regarding the request for TLSO brace :**

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

**4) Regarding the request for cold therapy unit :**

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

**5) Regarding the request for bone growth stimulator :**

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

**6) Regarding the request for 3:1 commode :**

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

**7) Regarding the request for front wheeled walker :**

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, 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.