

---

**Notice of Independent Medical Review Determination**

Dated: 8/20/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/2/2013  
Date of Injury: 10/11/1995  
IMR Application Received: 7/11/2013  
MAXIMUS Case Number: CM13-0001198

- 1) MAXIMUS Federal Services, Inc. has determined the request for L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 3 inpatient days **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for assistant surgeon **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for pre-op medical clearance **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a reacher **is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for a front wheel walker **is medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for a lumbar brace **is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/11/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/12/2013. 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 L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 3 inpatient days **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for assistant surgeon **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for pre-op medical clearance **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a reacher **is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for a front wheel walker **is medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for a lumbar brace **is 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 July 2, 2013;

“Report dated 06/20/13 reveals that the claimant returns with MRI. The claimant complains of persistent low back pain with bilateral lower extremity radiculopathy into the toes. The claimant also reports neurogenic claudication at 5-10 minutes. The claimant as a positive shopping cart sign reporting relief of lower extremity paresthesias in forward flexion. Medications include Ambien, Amlodipine besy benazepril, Butrans, Docolace, Duexis, Enalapril Maleate, Nexium, Norco and Valium.”

## 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
- Utilization Review by [REDACTED] (dated 7/2/13)
- Employee's Medical Records by [REDACTED] (dated 1/9/13 & 6/20/13)
- Diagnostic Imaging Report by [REDACTED] (dated 6/6/13)
- Employee's Medical Records by [REDACTED] (dated 2/15/12 thru 2/6/13)
- Employee's Medical Records by [REDACTED] (dated 2/13/12 thru 5/8/13)
- Employee's Medical Records by [REDACTED], MD (dated 6/4/12)
- Laboratory Report by [REDACTED] (dated 5/8/12)
- Employee's Medical Records by [REDACTED] (dated 3/27/12 thru 5/29/12)
- American College of Occupational And Environmental Medicine (ACOEM), Chapter 12 – Low Back Complaints, pg 307
- Official Disability Guidelines (ODG), Low Back Procedure Summary, Fusion (spinal)

### 1) Regarding the request for L4-5 decompression & Posterior lumbar interbody fusion L3 for decompression & possible fusion:

#### 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), 2<sup>nd</sup> Edition, (2004), Chapter 12 – Low Back Complaints, pg 307, which is part of the California Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines (ODG), which is not part of the 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 on 1/11/95. The employee has experienced ongoing back complaints with progressive pain and limitation in function. The records submitted and reviewed show the employee has failed conservative care with therapy, medications, activity modifications, and multiple injections. The request is for L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion, 3 inpatient days, assistant surgeon, pre-op medical clearance, reacher, front wheel walker, and a lumbar brace.

ACOEM guidelines state Referral for surgical consultation is indicated for patients who have failure of conservative treatment to resolve disabling radicular symptoms. The employee has ongoing pain complaints, failure of appropriate conservative care, and apparent progressive neurologic deficit. Medical records

reviewed document L3-4 retrolisthesis, L4-5 spondylolisthesis, and a previous L5-S1 fusion surgery. These records also document severe stenosis at L4-5 with progressive neurologic deficit. The request for L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion is medically necessary and appropriate.

**2) Regarding the request for 3 inpatient days:**

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

The Claims Administrator did not cite a guideline in its utilization review determination letter. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer stated no section of the MTUS was applicable and relevant to the issue at dispute. The Expert Reviewer relied on the Official Disability Guidelines (ODG), Hospital Length of Stay, which is not part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 1/11/95. The employee has experienced ongoing back complaints with progressive pain and limitation in function. The records submitted and reviewed show the employee has failed conservative care with therapy, medications, activity modifications, and multiple injections. The request is for L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion, 3 inpatient days, assistant surgeon, pre-op medical clearance, reacher, front wheel walker, and a lumbar brace.

The Official Disability Guidelines (ODG) recommends the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. ODG indicates the stay for a lumbar fusion with no complications is 3 days. The request for 3 inpatient days is medically necessary and appropriate.

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

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

The Claims Administrator did not cite a guideline in its utilization review determination letter. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer stated no section of the MTUS was applicable and relevant to the issue at dispute. The Expert Reviewer relied on the Milliman Care Guidelines (MCG), Inpatient and Surgical Care 17<sup>th</sup> Edition, Assistant Surgeon Guidelines, which is not part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 1/11/95. The employee has experienced ongoing back complaints with progressive pain and limitation in function. The records submitted and reviewed show the employee has failed conservative care with therapy, medications, activity modifications, and multiple injections. The request

is for L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion, 3 inpatient days, assistant surgeon, pre-op medical clearance, reacher, front wheel walker, and a lumbar brace.

The Milliman Care Guidelines (MCG) recommend an assistant surgeon for a lumbar fusion. The request for assistant surgeon is medically necessary and appropriate.

**4) Regarding the request for pre-op medical clearance:**

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

The Claims Administrator did not cite a guideline in its utilization review determination letter. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer stated no section of the MTUS was applicable and relevant to the issue at dispute. The Expert Reviewer relied on the Official Disability Guidelines (ODG), Preoperative Clearance, which is not part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 1/11/95. The employee has experienced ongoing back complaints with progressive pain and limitation in function. The records submitted and reviewed show the employee has failed conservative care with therapy, medications, activity modifications, and multiple injections. The request is for L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion, 3 inpatient days, assistant surgeon, pre-op medical clearance, reacher, front wheel walker, and a lumbar brace.

The Official Disability Guidelines (ODG) states that preoperative testing (e.g., chest radiography, electro-cardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. The medical records reviewed indicate the employee has progressive neurologic deficit.

The request for pre-op medical clearance is medical necessary and appropriate.

**5) Regarding the request for a reacher:**

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

The Claims Administrator did not cite a guideline in its utilization review determination letter. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer stated no section of the MTUS was applicable and relevant to the issue at dispute. The Expert Reviewer relied on the Official Disability Guidelines (ODG), Low Back Chapter, which is not part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 1/11/95. The employee has experienced ongoing back complaints with progressive pain and limitation in function. The records submitted and reviewed show the employee has failed conservative care with therapy, medications, activity modifications, and multiple injections. The request is for L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion, 3 inpatient days, assistant surgeon, pre-op medical clearance, reacher, front wheel walker, and a lumbar brace.

The employee is going to have significant limitations in motion following surgery. It can be difficult getting around, and a reacher can be used to help retrieve items of clothing and facilitate care around the house. The request for a reacher is medically necessary and appropriate.

**6) Regarding the request for front wheel walker:**

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

The Claims Administrator did not cite a guideline in its utilization review determination letter. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer stated no section of the MTUS was applicable and relevant to the issue at dispute. The Expert Reviewer relied upon the Official Disability Guidelines (ODG), Low Back Chapter, Front-wheeled walker, which is not part of the California Medical Treatment Utilization Schedule (MTUS) and

Rationale for the Decision:

The employee was injured on 1/11/95. The employee has experienced ongoing back complaints with progressive pain and limitation in function. The records submitted and reviewed show the employee has failed conservative care with therapy, medications, activity modifications, and multiple injections. The request is for L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion, 3 inpatient days, assistant surgeon, pre-op medical clearance, reacher, front wheel walker, and a lumbar brace.

The employee will have some gait issues after surgery, and a walker is within guidelines and can be used to help mobilize the employee. The request for a front wheel walker is medically necessary and appropriate.

**7) Regarding the request for lumbar brace:**

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

The Claims Administrator did not cite a guideline in its utilization review determination letter. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer stated no section of the MTUS was applicable and relevant to the issue at dispute. The Expert Reviewer relied upon the Official Disability Guidelines (ODG), Low Back Chapter, Lumbar

supports, which is not part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 1/11/95. The employee has experienced ongoing back complaints with progressive pain and limitation in function. The records submitted and reviewed show the employee has failed conservative care with therapy, medications, activity modifications, and multiple injections. The request is for L4-5 decompression & posterior lumbar interbody fusion L3 for decompression & possible fusion, 3 inpatient days, assistant surgeon, pre-op medical clearance, reacher, front wheel walker, and a lumbar brace.

The Official Disability Guidelines (ODG) Recommends lumbar supports as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. The requested lumbar off-the-shelf brace is medically necessary to give the claimant some stability, soft tissue control, and help decrease pain issues in the postoperative time frame. The request for a lumbar brace is 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/ldh

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.