

**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: 10/2/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/11/2013
Date of Injury:	2/14/2012
IMR Application Received:	7/18/2013
MAXIMUS Case Number:	CM13-0002208

- 1) MAXIMUS Federal Services, Inc. has determined the request for Posterior Lumbar Interbody Fusion L2-3, L3-4, L4-5; bone graft; pedicle screw fixation, implants **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 Posterior Lumbar Interbody Fusion L2-3, L3-4, L4-5; bone graft; pedicle screw fixation, implants **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 Neurological Surgery has a subspecialty in Complex Spine 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 11, 2013:

“Patient was diagnosed with “Multilevel degenerative disc disease at L2, L3, L4, L5, with associated facet hypertrophy, disc protrusions and lateral recess and foraminal stenosis. Transitional L5-S1 Segment without disc disease.”

### **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 (received 7/11/13)
- Utilization Review Determination from [REDACTED] (dated 7/15/13)
- Employee Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request for Posterior Lumbar Interbody Fusion L2-3, L3-4, L4-5; bone graft; pedicle screw fixation, implants:**

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

The Claims Administrator based its decision on Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12) pg. 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 sustained a work-related injury on February 14, 2012. The medical records provided for review indicate the diagnoses of multilevel degenerative disc disease at L2, L3, L4, L5 with associated facet hypertrophy, disc protrusions and lateral recess and foraminal stenosis. Treatments have included chiropractic manipulation, physical therapy, epidural injections, and medication management. The request is for posterior lumbar interbody fusion L2-3, L3-4, L4-5; bone graft; pedicle screw fixation, implants.

The MTUS ACOEM guidelines indicate that the surgical treatment for spinal stenosis is usually a complete laminectomy and there is not enough evidence to indicate that spinal fusion is effective in relieving back pain. The medical records reviewed indicate spinal instability is only present at L2-3, and therefore fusion at L4-5 and L5-S1 does not meet guideline criteria. The request for posterior lumbar interbody fusion L2-3, L3-4, L4-5; bone graft; pedicle screw fixation, implants **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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/hs

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.