

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/22/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/3/2013
Date of Injury: 3/1/2010
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003424

- 1) MAXIMUS Federal Services, Inc. has determined the request for decompression and fusion with instrumentation at L5-S1 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for PO HHC eight hours a day for four weeks followed with four hours a day for two weeks **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Thermo cool hot/cold therapy with compression unit for sixty days **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Combo care 4 **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for front wheeled walker **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for 3 in 1 commode **is not medically necessary and appropriate.**

- 7) MAXIMUS Federal Services, Inc. has determined the request for LSO back brace **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for bone growth stimulator **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for DVT prophylaxis **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 decompression and fusion with instrumentation at L5-S1 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for PO HHC eight hours a day for four weeks followed with four hours a day for two weeks **is not medically necessary and appropriate.**
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- 8) MAXIMUS Federal Services, Inc. has determined the request for bone growth stimulator **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for DVT prophylaxis **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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 3, 2013:

“ According to clinical documentation, the patient is a 45-year-old individual who sustained an injury on 3/1/10. The patient slipped on a wet floor and fell backwards hitting the entire back and the back of the head against the tile floor. There was a previous adverse determination dated 5/3/13 whereby the previous reviewer, Dr. [REDACTED] non-certified the request for decompression and fusion at L5-S1. The reviewer noted that "The medical records demonstrate that when she was seen on 04/19/13, "motor and sensory examination [was] intact to the bilateral lower extremities." ACOEM Guidelines indicate that for a decompression, there should be severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise; and 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. There should be documentation of a failure of conservative treatment to resolve those disabling radicular symptoms. As she did not have functional deficits that could be appreciated to the L5-S1 level, decompression is not considered supported by guidelines. Furthermore, guidelines also indicate that for a fusion, there should be a psychosocial evaluation prior to the surgery. That has not been provided for this review. Therefore, the decompression and fusion at L5-S1 is not considered medically necessary or appropriate." Requests for post-operative home health care for wound cleaning and assistance with daily living activities - 8 hours daily for 4 weeks, followed by 4 hours a day for 2 weeks; 60 day rental of a ThermoCool Compression System; rental of a Combo Care 4, electrotherapy; deep vein thrombosis prophylaxis; front wheeled walker for purchase; and bone growth stimulator were also non-certified. The previous reviewer noted that surgical intervention has not been considered reasonable and necessary. Lumbosacral orthosis (LSO) was also non-certified whereby the previous reviewer noted that "ACOEM Guidelines indicate that a back brace is reasonable in the "acute" phase. This patient is not in the acute phase, and surgery has not been considered reasonable." According to Primary Treating Physician's Post Permanent and Stationary Re-Evaluation Report dated by 5/31/13 Dr. [REDACTED] the patient was previously deemed to be at maximum medical improvement and permanent and stationary on 7/30/12 by Qualified Medical Evaluator (QME) Dr. [REDACTED] This visit was a part of the provision for future medical care as recommended in the QME report. The patient continued to complain of pain to the back radiating down to the leg. The patient cannot tolerate the symptoms. Authorization for surgery was denied even though the QME Dr. [REDACTED] indicated in the July 2012 report that the patient was a surgical candidate if the patient failed conservative treatment, including lumbar ESI. On examination, the patient had an antalgic gait on the right side. The patient was using a cane for support. There was decreased range of motion of lumbosacral spine. Straight leg raise test caused back pain. Reflexes were symmetrical. QME Supplemental report dated 5/15/13 by Dr. [REDACTED] was reviewed which documented opinion "Several of the sub-rosa tapes do show the patient taking and putting on shoes without much difficulty. Outside of this, the activity is quite light, and there is nothing which I would categorize as even moderate activity in this. At face value, the sub-rosa tapes do not change any of my prior opinions." Over the past three years, the patient had gone through an aggressive course of conservative treatment and continued to be symptomatic. Because of limitation of activities of daily living (ADL) and failure to respond to conservative treatment, the patient was recommended to undergo surgical treatment in the form of decompression and fusion with instrumentation at L5-S1. Absent the abovementioned surgery, there was no additional treatment that

will be able to render the patient. If the patient proceeds with the surgery, the patient was recommended to receive postoperative Home Health Care for the purpose of wound cleaning and assistance with daily living activities. ThermoCool hot and cold contrast therapy with compression was also requested for a period of 60 days for pain control, reduction of inflammation, and increased circulation. This multi-modality treatment was preferred over simple ice and heat packs for the additional benefits of compression as well as increased patient compliancy and the regulation of temperature to prevent over icing or overheating, which can cause tissue damage and delays in functional restoration. Combo Care 4, electrotherapy was also requested as a multimodality approach to pain control and functional restoration. Deep vein thrombosis prophylaxis was also requested as a preventive measure against the increased likelihood of developing venothromboembolism (VTE) following surgical procedure. Front wheel walker, 3 in 1 commode, LSO back brace and bone growth stimulator were also requested to be utilized post surgically. The patient was permanently partially disabled per QME, Dr. [REDACTED]. According to Internal Medicine Consultation Permanent and Stationary Report dated 3/5/13 by Dr. [REDACTED] the patient had reached maximum medical improvement and was permanent and stationary from an internal medicine standpoint as of the date of this evaluation. Magnetic resonance imaging (MRI) scan of the lumbar spine dated 2/27/13 interpreted by Dr. [REDACTED] in comparison with 4/7/12 documented that at L5-S1, there was loss of disc signal with mild loss of dorsal disc height. There was mild ventral subluxation by 4 mm. Broad annular bulge was noted. There were mild degenerative facet changes. Mild bilateral foraminal stenosis noted. In conclusion, transitional lumbosacral segment, for consistency in counting purposes from prior MRI dictation, will again be referred to as a lumbarized S1; bilateral L5 spondylolysis and mild grade 1 spondylolisthesis and spondylosis at L5-S1 resulting in mild bilateral foraminal stenosis; remainder of the lumbar disc levels were unremarkable; and no significant interval change since 4/7/12. Operative Report dated 1/23/13 by Dr. [REDACTED] the patient had a lumbar transforaminal epidural steroid injection (ESI) at L4 and L5 on the left side with epidurography. Operative Report dated 9/12/12 by Dr. [REDACTED] documented that the patient underwent left-sided L5 and S1 transforaminal epidural steroid injection (ESI) under fluoroscopic guidance with epidurogram. According to Qualified Medical Evaluation (QME) dated 7/30/12 by Dr. [REDACTED]. The patient underwent the functional capacity assessment. The QME report 7/30/12 was incomplete. According to QME dated 6/12/12 by Dr. [REDACTED] the patient was evaluated on 8/29/11 for QME. Further medical care was recommended to include lumbar ESI. If the ESI were ineffective in relieving the low back and left leg pain, then the patient may require surgery. Surgical history included left elbow surgery on 1/17/05; left hand surgery in 2004; left knee surgery in 2003 or 2004; and cholecystectomy on 5/13/12. The patient had high blood pressure. There was no documentation of psychological evaluation in the clinical report submitted with this request. The patient was diagnosed with cervical strain; bilateral L5 pars interarticularis defect with L4-L5 stenosis and L5-S1 spondylitic spondylolisthesis with discogenic back pain and radiculopathy; psychological diagnoses, deferred to Dr. [REDACTED] and internal diagnoses, deferred to Dr. [REDACTED]

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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 7/25/13)
- Utilization Review Determination from [REDACTED] (dated 7/3/13)
- Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for decompression and fusion with instrumentation at L5-S1 :

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 (ACEOM Practice Guidelines, 2nd Edition (2004), Chapter 12, pg. 308-310, which is part of MTUS as well as the Official Disability Guidelines (ODG), current version, Low Back Chapter, indications for surgery, which is a Medical Treatment Guideline (MTG), but not part of MTUS,. 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 an industrial injury on 3/1/2010. A review of the records submitted for review indicate that a 2/27/13 lumbar MRI shows bilateral L5 spondylolysis with mild grade 1 spondylolisthesis and spondylosis at L5/S1 resulting in mild bilateral foraminal stenosis. This is the spondylolytic spondylolisthesis that Dr [REDACTED] refers to on his 5/31/13 report. The employee had two lumbar ESIs without significant benefit. There was 3 years of conservative care including PT and psychotherapy. The orthopedic QME, Dr [REDACTED], felt that if the ESIs did not help, the employee would require surgery. A request was made for decompression and fusion with instrumentation at L5-S1.

Per the guidelines, pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology correlated with symptoms and exam findings; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. There is no indication that there was a pre-operative psych screening as recommended in the guidelines. The request for decompression and fusion with instrumentation to L5-S1 **is not medically necessary and appropriate.**

2) Regarding the request for PO HHC eight hours a day for four weeks followed with four hours a day for two weeks :

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

3) Regarding the request for Thermo cool hot/cold therapy with compression unit for sixty days :

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

4) Regarding the request for Combo care 4 :

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

- 5) Regarding the request for front wheeled walker :**
Since the primary procedure is not medically necessary, none of the associated services are medically necessary
- 6) Regarding the request for 3 in 1 commode :**
Since the primary procedure is not medically necessary, none of the associated services are medically necessary
- 7) Regarding the request for LSO back brace :**
Since the primary procedure is not medically necessary, none of the associated services are medically necessary
- 8) Regarding the request for bone growth stimulator :**
Since the primary procedure is not medically necessary, none of the associated services are medically necessary
- 9) Regarding the request for DVT prophylaxis :**
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,

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th 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.