

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/2/2013  
Date of Injury: 3/1/2010  
IMR Application Received: 7/25/2013  
MAXIMUS Case Number: CM13-0003471

Dear [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

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## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and has a subspecialty in 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 physician 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 disputed items/services.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 45-year-old female who reported a work related injury on 03/01/2010, as the result of a fall. Subsequently, the patient presents for treatment of the following diagnoses, cervical spine sprain/strain and lumbar spine sprain/strain. The clinical note dated 10/28/2013 reported the patient was seen under the care of Dr. [REDACTED]. The provider documents the patient has not been seen since 06/29/2012. Documents reflect that the patient was found to have reached MMI as of 07/30/2012., and that the patient currently presents back pain that has gotten progressively worse. The patient reports her left lower extremity is feeling more weak and numb and was having difficulties with control of her bowel and bladder. The provider notes that the patient underwent epidural steroid injections in September which actually made her pain worse. The patient states she cannot tolerate her symptoms and would like to have surgical treatment for her back. Upon physical exam of the patient, evidence of an antalgic gait on the left side was noted. The patient was unable to walk on her heels or tip toes secondary to back and leg pain. There was decreased sensation in a left L4, L5, and S1 distribution. Straight leg raise testing was positive on the left and negative on the right. The patient's reflexes were symmetrical and clonus was not present. The provider reviewed the clinical documents evidencing her course of treatment since she had last been seen in clinic with recommendations for weight loss and smoking cessation. An MRI of the patient's lumbar spine dated 02/27/2013 signed by Dr. [REDACTED] revealed: (1) transitional lumbosacral segment (for consistency and counting purposes) from prior lumbar MRI dictation will again be referred to as lumbarized S1; (2) bilateral L5 spondylosis and mild grade I spondylolisthesis and spondylosis at L5-S1 resulting in mild bilateral foraminal stenosis; (3) remained of the lumbar discs are unremarkable; (4) no significant interval changes since 04/07/2012. Electrodiagnostic studies of the bilateral upper and lower extremities dated 06/13/2013 signed by Dr. [REDACTED] revealed: (1) right wrist carpal tunnel syndrome definite to modest; (2) residuals of old left wrist carpal tunnel syndrome; (3) equivocal irritability in the right lower extremity medial gastrocnemius muscle of uncertain significance. The clinical note dated 05/31/2013 reports the patient was seen for follow up again under the care of Dr. [REDACTED]. The provider documents the patient continues to present with

complaints of back pain radiating down the lower extremity. Upon physical exam of the patient, the provider documents an antalgic gait on the right side on this clinical note and that the patient uses a cane for support. The patient presents with decreased range of motion of the lumbosacral spine, straight leg raise testing causes back pain, and the reflexes are symmetrical. The provider subsequently recommended surgical treatment in the form of decompression and fusion with instrumentation at L5-S1, Thermo cool hot and cold contrast therapy with compression, electro therapy, and deep vein thrombosis prophylaxis.

### **IMR DECISION(S) AND RATIONALE(S)**

The Final Determination was based on decisions for the disputed items/services set forth below:

**1. Decompression and fusion with instrumentation at L5-S1 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12) pgs. 308-310, which is part of the MTUS

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12), which is part of the MTUS.

The Physician Reviewer's decision rationale: The current request previously received an adverse determination as there was a lack of evidence of any motor, neurological, or sensory deficits upon physical exam of the employee to support decompression. In addition, California MTUS/ACOEM Guidelines indicate that for 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 electrophysiological evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair." The employee did not present with motor, neurological, or sensory deficits that correlated with imaging studies of the lumbar spine, the current requested operative procedure is not supported. The medical records provided for review lacked evidence of the employee having undergone a psychological evaluation prior to the requested operative procedure as recommended via guidelines to address any confounding issues that may impede postoperative recovery. **The request for decompression and fusion with instrumentation at L5-S1 is not medically necessary and appropriate**

**2. PO HHC eight hours a day for four weeks followed by four hours a day for two weeks is not medically necessary and appropriate.**

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

**3. Thermo cool hot/cold therapy is not medically necessary and appropriate.**

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

**4. Combo Care 4 is not medically necessary and appropriate.**

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

**5. Front wheel walker is not medically necessary and appropriate.**

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

**6. 3 in 1 commode is not medically necessary and appropriate.**

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

**7. LSO back brace is not medically necessary and appropriate.**

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

**8. Bone growth stimulator is not medically necessary and appropriate.**

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

**9. DVT prophylaxis not medically necessary and appropriate.**

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

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.

[REDACTED]

CM13-0003471