

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/30/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/18/2013
Date of Injury:	1/3/2008
IMR Application Received:	7/26/2013
MAXIMUS Case Number:	CM13-0003553

- 1) MAXIMUS Federal Services, Inc. has determined the request for a multilevel posterior lumbar fusion **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for pre-op medical clearance **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for MRI of the lumbar spine **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. 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 a multilevel posterior lumbar fusion **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for pre-op medical clearance **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for MRI of the lumbar spine **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The 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 utilization review summary did not contain a clinical summary.

### **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 Determination from Claims Administrator
- Employee medical records from Claim Administrator
- Medical Treatment Utilization Schedule (MTUS)

### **1) Regarding the request for a multilevel posterior lumbar fusion:**

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

The Claims Administrator cited the California Medical Treatment Utilization Schedule (MTUS), but did not cite a specific section. The Expert Reviewer relied on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition, (2004), Low Back Chapter, Surgical Considerations,

pages 305-306, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee injured the neck, back, both shoulders, and both wrists after falling in the workplace on 1/3/2008. The request is for a multilevel posterior lumbar fusion.

The ACOEM guidelines indicate that there should be documentation of radiculopathy and failure of conservative measures prior to undergoing this procedure. It was further indicated there was no specific levels requested for the fusion. The medical records submitted and reviewed fail to indicate a specific level indicating that multilevel posterior lumbar fusion is requested, a psychosocial evaluation as recommended by guidelines and there is lack of documentation of conservative care as no physical therapy notes were provided for this review and no interventional injection notes were provided for this review. Guidelines indicate 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 prior to undergoing surgical interventions such as this. The guideline criteria have not been met. **The request for a multilevel posterior lumbar fusion is not medically necessary and appropriate.**

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

Since the multilevel posterior lumbar fusion is not medically necessary, none of the associated services are medically necessary and appropriate.

**3) Regarding the request for a MRI of the lumbar spine:**

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 Expert Reviewer relied on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition, (2004), Low Back Chapter, Special Studies and Diagnostics and Table 12-7, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee injured the neck, back, both shoulders, and both wrists after falling in the workplace on 1/3/2008. The request is for a MRI of the lumbar spine. The ACOEM guidelines indicate that relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion. Imaging studies should be reserved for cases in which surgery is considered and red flag diagnoses are being evaluated. Surgical intervention in this case is not being considered and this employee has already had 2 previous MRIs of the lumbar spine. The rationale for proceeding with a third MRI has not been demonstrated as there is lack of documentation of significant progressive neurological deficits and the surgical intervention itself is not medically necessary. **The request for a MRI of the lumbar spine 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

/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.