MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 12/6/2013

[redacted]

[redacted]

Employee:	[redacted]
Claim Number:	
Date of UR Decision:	7/31/2013
Date of Injury:	4/7/2011
IMR Application Received:	8/9/2013
MAXIMUS Case Number:	CM13-0009441

1) **MAXIMUS Federal Services, Inc. has determined the request for 1 lumbar laminoforaminotomy of the left L4-L5 and L5-S1 is medically necessary and appropriate.**

2) **MAXIMUS Federal Services, Inc. has determined the request for medical clearance is medically necessary and appropriate.**

3) **MAXIMUS Federal Services, Inc. has determined the request for laboratory tests is medically necessary and appropriate.**

4) **MAXIMUS Federal Services, Inc. has determined the request for 23 hour observation stay is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/9/2013disputing the Utilization Review Denial dated 7/31/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 1 lumbar laminoforaminotomy of the left L4-L5 and L5-S1** is **medically necessary and appropriate.**

2) **MAXIMUS Federal Services, Inc. has determined the request for medical clearance is medically necessary and appropriate.**

3) **MAXIMUS Federal Services, Inc. has determined the request for laboratory tests is medically necessary and appropriate.**

4) **MAXIMUS Federal Services, Inc. has determined the request for 23 hour observation stay** 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.

Expert Reviewer Case Summary:
The patient has documented L4-5 and L5-S1 spinal stenosis. He has had symptoms related to his 2 level lumbar stenosis since 2011. His laminectomy surgery was approved in 2011. He decided not to have it and instead had more conservative measures such as PT and medications. He continues tohavesymptoms andhas now been reindicated for the same dcompression at L4-5 andL5-S1. At issue is whether this procedure is medically needed.

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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for 1 lumbar laminoforaminotomy of the left L4-L5 and 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 Prevention (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 1) and Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004) Table 2, Summary of Recommendations, Low Back Disorders, which are part of MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on (1) Interventional techniques: evidence-based practice guidelines in the management of chronic spinal pain. Boswell MV, Trescot AM, Datta S, Schultz DM, Hansen HC, Abdi S, Sehgal N, Shah RV, Singh V, Benyamin RM, Patel VB, Buenaventura RM, Colson JD, Cordner HJ, Epter RS, Jasper JF, Dunbar EE, Atluri SL, Bowman RC, Deer TR, Swicegood JR, Staats PS, Smith HS, Burton AW, Kloth DS, Giordano J, Manchikanti L; American Society of Interventional Pain Physicians. Pain Physician. 2007 Jan;10(1):7-111. (2 Interventional techniques in the management of chronic spinal pain: evidence-based practice guidelines. Boswell MV, Shah RV, Everett CR, Sehgal N, McKenzie Brown AM, Abdi S, Bowman RC 2nd, Deer TR, Datta S, Colson JD, Spillane WF, Smith HS, Lucas LF, Burton AW, Chopra P, Staats PS, Wasserman RA, Manchikanti L. Pain Physician. 2005 Jan;8(1):1-47. (3) [Lumbar spinal stenosis]. Schulte TL, Bullmann V, Lerner T, Schneider M, Marquardt B, Liljenqvist U, Pietilä TA, Hackenberg L. Orthopade. 2006 Jun;35(6):675-92; quiz 693-4. Review. German. PMID: 16770609 [PubMed - indexed for MEDLINE] Related citationspter 12, which are not part of MTUS.

Rationale for the Decision:
The patient has spinal stenosis symptoms related to both L4-5 and L5-S1 and has clearly failed multiple attempts at conservative measures since 2011 to include PT, Meds. Injections are controversial and not likely to provide longterm relief of spinal stenosis. They are not the next best treatment option in this patient who has symptoms since 2011 and they are not more likely to provide lasting relief like surgery will do. Surgery for laminectomy is the next best option in this case and the most appropriate treatment at this time. **The request for 1 lumbar laminoforaminotomy of the left L4-L5 and L5-S1** is **medically necessary and appropriate.**

2) **Regarding the request for medical clearance:**

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 Prevention (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 1) and Low Back Complaints (ACOEM

Practice Guidelines, 2nd Edition (2004) Table 2, Summary of Recommendations, Low Back Disorders, which are part of MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Feely MA, Collins CS, Daniels PR, Kebede EB, Jatoi A, Mauck KF. Source Division of General Internal Medicine, Mayo Clinic, Rochester, MN 55905, USA. feely.molly@mayo.edu. Abstract - Preoperative testing (e.g., chest radiography, electrocardiography, 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. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing.

Rationale for the Decision:
Standard preop workup for this type of appropriate surgery**. The request for medical clearance is medically necessary and appropriate.**

3) Regarding the request for laboratory tests:

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 Prevention (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 1) and Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004) Table 2, Summary of Recommendations, Low Back Disorders, which are part of MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Am Fam Physician. 2013 Mar 15;87(6):414-8. Preoperative testing before noncardiac surgery: guidelines and recommendations. Feely MA, Collins CS, Daniels PR, Kebede EB, Jatoi A, Mauck KF. Source Division of General Internal Medicine, Mayo Clinic, Rochester, MN 55905, USA. feely.molly@mayo.edu. Abstract - Preoperative testing (e.g., chest radiography, electrocardiography, 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. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing.

Rationale for the Decision:
Part of routine standard preop testing before laminectomy**. The request for laboratory tests is medically necessary and appropriate.**

4) **Regarding the request for 23 hour observation stay:**

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 Prevention (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 1) and Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004) Table 2, Summary of Recommendations, Low Back Disorders, which are part of MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on J Perianesth Nurs. 2004 Apr;19(2):84-8. Development of a same day laminectomy program. Scanlon J, Richards B. Source Kaiser Permanente Medical Center, Sacramento, CA 95864, USA. Abstract - Historically, patients undergoing a lumbar laminectomy for discectomy (LLD) have been admitted to the hospital for 1 to 3 days. Because a patient undergoing a surgical procedure is not necessarily medically ill, many surgical procedures are now performed on an outpatient basis. A multidisciplinary nursing team proposed that some patients scheduled to undergo an LLD would be able to have this surgery as an outpatient. A 6-month research project was developed to study outcomes of patients undergoing LLD who were discharged after 4 to 6 hours of postoperative care in the PACU. Guidelines were established to define the candidates for enrollment in the same day LLD. A patient clinical pathway was established, and outcome monitors were selected. Twenty-seven patients were enrolled in this study. This article describes the process of development, application, and future implications of this study. PMID: 15069647 [PubMed - indexed for MEDLINE] Spine J. 2013 Feb;13(2):134-40. doi: 10.1016/j.spinee.2012.10.028. Epub 2012 Dec 5. Postoperative spinal epidural hematoma (SEH): incidence, risk factors, onset, and management. Amiri AR, Fouyas IP, Cro S, Casey AT. Source Spinal Injury Unit, Royal National Orthopaedic Hospital, Brockley Hill, Stanmore, Middlesex, HA7 4LP, United Kingdom. amir.r.amiri@googlemail.com. Abstract - BACKGROUND CONTEXT: Spinal epidural hematoma (SEH) is a rare, yet potentially devastating complication of spinal surgery. There is limited evidence available regarding the risk factors and timing for development of symptomatic SEH after spinal surgery. PURPOSE: To assess the incidence, risk factors, time of the onset, and effect of early evacuation of symptomatic SEH after spinal surgery. STUDY DESIGN: Multicenter case control study. PATIENT SAMPLE: All patients who underwent open spinal surgery between October 1, 1999, and September 30, 2006, at the National Hospital For Neurology and Neurosurgery (NHNN) and the Wellington Hospital (WH) were reviewed. OUTCOME MEASURES: Frankel grade. METHODS: Patients who developed SEH and underwent evacuation of the hematoma were identified. Two controls per case were selected. Each control had undergone a procedure with similar complexity, at the same section of the spine, at the same hospital, and under the same surgeon within 6 months of the

initial operation. RESULTS: A total of 4,568 open spinal operations were performed at NHNN and WH. After spinal surgery, 0.22% of patients developed symptomatic SEH. Alcohol greater than 10 units a week (p=.031), previous spinal surgery (p=.007), and multilevel procedures (p=.002) were shown to be risk factors. Initial symptoms of SEH presented after a median time of 2.7 hours (interquartile range [IQR], 1.1-126.1). Patients who had evacuation surgery within 6 hours of the onset of initial symptoms improved a median of 2 (IQR, 1.0-3.0) Frankel grades, and those who had surgery more than 6 hours after the onset of symptoms improved 1.0 (IQR, 0.0-1.5) Frankel grade, p=.379. CONCLUSIONS: Symptomatic postoperative SEH is rare, occurring in 0.22% of cases. Alcohol consumption greater than 10 units a week, multilevel procedure, and previous spinal surgery were identified as risk factors for developing SEH. Spinal epidural hematoma often presents early in the postoperative period, highlighting the importance of close patient monitoring within the first 4 hours after surgery. This study suggests that earlier surgical intervention may result in greater neurological recovery.

Rationale for the Decision:
23 hour stay after 2 level laminectomy is the standard of care and appropriate. **The request for 23 hour observation stay** 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
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