

Case Number:	CM13-0057206		
Date Assigned:	04/16/2014	Date of Injury:	12/03/2012
Decision Date:	06/30/2014	UR Denial Date:	11/04/2013
Priority:	Standard	Application Received:	11/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Neurosurgery 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

The patient submitted a claim for radiculopathy L5-S1 and S1-S2, left distribution and lumbar strain associated with an industrial injury date of 12/03/2012. Treatment to date has included L4-S1 microdiscectomy, lumbar epidural steroid injection, physical therapy, and medications including Vicodin, gabapentin, Neurontin, and Xanax. A utilization review from 11/04/2013 denied the request for intraoperative neuro monitoring because the planned procedure was a surgical decompression without the use of any implanted instrumentation which does not carry the same risks of significant complication as fusion surgery does. Medical records from 2013 to 2014 were reviewed showing that patient complained of right-sided low back pain with shooting pain along the gluteal and posterior thigh on the left side associated with burning, numbness and pins and needles sensation on the left anterior thigh. Back pain was rated 7/10 in severity, right leg pain 4/10, and left leg pain 8/10 and worsened upon prolonged sitting greater than 30 minutes, standing greater than 30-45 minutes, walking greater than half a mile, and bending forward. Pain was alleviated with lying down. An Oswestry form for the low back was completed revealing a score of 56/100 with severe difficulty with pain, moderate to severe difficulty with employment/homemaking, and moderate difficulty with traveling, social life, standing, and lifting. Physical examination showed tenderness of the paralumbar muscles and mid-lumbar spine above his incision. Range of motion of lumbar spine showed flexion 35/60, extension 15/25, and lateral bending 15/25. Motor strength showed 4/5 weakness at left extensor hallucis longus. He had mildly antalgic gait. The patient was able to perform heel-to-toe walk. Reflexes were equal and symmetric. Sensation was diminished to light touch in the anterolateral thigh and anterolateral calf on the left. MRI of the lumbar spine from 09/23/2013 revealed broad-based disc protrusions at L4-L5 and L5-S1. There was very mild neuroforaminal narrowing and no central narrowing.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTRAOPERATIVE NEURO MONITORING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Intraoperative neurophysiological monitoring

Decision rationale: CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back Chapter was used instead. Intraoperative neurophysiological monitoring is utilized in attempts to minimize neurological morbidity from operative manipulations. The following types of intraoperative monitoring may be necessary: somatosensory-evoked potentials; brainstem auditory-evoked potentials; EMG of cranial or spinal nerves; EEG; & electrocorticography (ECOG). Intraoperative EMG and nerve conduction velocity monitoring on peripheral nerves during surgery is not recommended. However, in the majority of routine orthopedic spine procedures, mostly laminectomy, discectomy, or spinal fusion surgeries, procedures that do not actually involve the spinal cord itself but are very close to the spinal cord, the use of monitoring should be at the discretion of the surgeon. In this case, the patient underwent L4-S1 microdiscectomy dated 12/18/2013; however the official operative report is not included in the medical records submitted for review. It is unclear if the patient received intraoperative neuro monitoring at that time. The specific type of neuro monitoring is not indicated. There was likewise no documented rationale for its use in a microdiscectomy procedure. Therefore, with the documentation submitted, the request for intraoperative neuro monitoring is not medically necessary.