MAXIMUS Federal Services

Case Number:	CM14-0044670		
Date Assigned:	08/06/2014	Date of Injury:	11/09/2011
Decision Date:	09/12/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/11/2014

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 Neurology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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:

3/21/14 note indicates continued pain in the neck with radiation to both arms. X-rays reported to show severe degenerative disc disease at C4-5 and C6-7 with kyphosis. Examination reports no focal neurological deficits. Range of motion in the cervical spine is reduced. Treating physician note limited guarantees of improvement in clinical symptoms with any surgery. 3/18/14 note indicates ongoing pain with muscle spasms. 5/13 MRI was reported to show mild cervical spondylosis with mild spinal stenosis at C5-6. Examination reported to show normal alignment with reduced range of motion in the cervical spine. There was no tenderness to palpation. There was normal strength and reflexes with negative Hoffman's sign and spurling's.

IMR ISSUES, DECISIONS AND RATIONALES

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

C4-6 Anterior Discectomy and Fusion microsurgical techniques: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (updated 03/07/2014): Discectomy-laminectomy-laminoplasty.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck, discectomy/laminectomy.

Decision rationale: The medical records provided for review do not support the presence of spinal instability, muscle weakness or reflex changes in support of a medical necessity for surgery. ODG supports that there should be evidence of motor deficit or reflex changes or positive EMG findings that correlates with the cervical level.

Intra-Operative Nerve Conduction, Cervical Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck, intraoperative neurophysiologic monitoring.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Intra-Operative Evoked Potential, Upper And Lower Limbs: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck, intraoperative neurophysiologic monitoring.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Intra-Operative Needle Electromyography, 2 Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) < neck, intraoperative neurophysiologic monitoring.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Intra-Operative Neurophysiology Testing Per Hour: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck, intraoperative neurophysiologic monitoringRecommended during spinal or intracranial surgeries when such procedures have a risk of significant complications that can be detected and prevented through use of neurophysiological monitoring. Not recommended in low-risk elective surgery. 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. Intraoperative monitoring is not recommended for intraoperative visual-evoked potentials and motor-evoked potentials. See the Low Back Chapter for more information and references. In the neck, for low-risk elective cervical spine surgery for degenerative conditions, intraoperative neuromonitoring (IOM) adds significantly to the cost of the procedure without a corresponding benefit in safety or patient outcomes, according to a new study. While IOP is widely used in spine surgery, the various modalities have not been clearly linked to better patient outcomes, only additional costs. IOM use increased 531% among Medicare beneficiaries between 2001 and 2011, with spending on IOM over $23 million in 2011. Although IOM is critical for many procedures and patient populations, there are low-risk populations for whom it might safely be eliminated, the study suggests. In this study, IOM procedural costs were increased by about $5000 per patient. The findings pertain only to low-risk populations, and the data should not be extrapolated to complex cases, such as multiple reoperations, trauma, deformities, and cord compression. (Godil, 2013).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.