Case Number:	CM14-0069163		
Date Assigned:	07/14/2014	Date of Injury:	02/13/1998
Decision Date:	08/11/2014	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	05/14/2014

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 Orthopaedic 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 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:

This 68-year-old male sustained an industrial injury on 2/13/98. Injury occurred when he slipped and fell backwards onto his left side while walking up stairs. The 3/30/14 lumbar MRI impression documented multilevel degenerative joint disc disease from L2/3 to L5/S1 producing spinal canal, lateral recess and neuroforaminal narrowing. There was impingement of the cauda equina, left L3, and bilateral L4 exiting nerve roots, with marked narrowing at L4/5. The 4/15/14 neurosurgical report cited progressively worsening back pain with significant difficulty walking secondary to right leg pain. Physical exam demonstrated antalgic gait and breakaway strength on the right with heel walk and severe flank pain. He was able to toe walk. Lower extremity sensation and deep tendon reflexes were intact and symmetrical. There was no focal tenderness. The patient had severe L4/5 stenosis and associated neurogenic claudication and back pain. He had failed conservative non-operative care. Given the severity of the stenosis, an L4/5 laminectomy without fusion was recommended. Intraoperative neurophysiologic monitoring was requested. Surgical approval was noted. The 5/8/14 utilization review denied the request for intraoperative neurophysiologic monitoring as there was no clear indication why this was necessary in the absence of a fusion procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intra-operative Neurophysiology Testing: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines), Treatment in Workers Comp 18th edition, 2013 UpdatesLow Back Chapter Intra-operative neurophysiological monitoring (during surgery).

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 - Lumbar & Thoracic, Intraoperative neurophysiological monitoring (during surgery).

Decision rationale: The Official Disability Guidelines state that intraoperative neurophysiological monitoring during spine surgery is currently accepted as standard practice for many procedures and should be used at the discretion of the surgeon to improve outcomes of spinal surgery. 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. Guideline criteria have been met. Guidelines suggest that intraoperative neurophysiologic monitoring is be left to the discretion of the surgeon. There is severe central canal stenosis with impingement of the cauda equina and exiting nerve roots at the surgical level. Given the immediate proximity of the spinal cord to the surgical site, this request is reasonable. Therefore, this request for intraoperative neurophysiologic monitoring is medically necessary.