

Case Number:	CM14-0038482		
Date Assigned:	06/27/2014	Date of Injury:	06/06/2013
Decision Date:	02/03/2015	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/01/2014

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 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 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 injured worker is a 50-year-old male who reported an injury of unspecified mechanism on 06/06/2013. On 03/05/2014, his complaints included severe low back pain which radiated down his left lower leg. Upon examination, his left lower extremity pain was along the L5 and S1 distributions. He had weakness with knee flexion, extension, dorsiflexion, and plantar flexion on the left side. He had an absent left patellar reflex. He was noted to have participated in 8 physical therapy sessions between 01/02/2014 and 01/30/2014. He was able to increase his range of motion and decrease his pain with activities. 8 more sessions of physical therapy were ordered. There was no documentation of the subsequent visits of physical therapy. An MRI of the lumbar spine on 08/19/2013 revealed multilevel degenerative disc disease, especially at the levels of L4-5 and L5-S1. There was no evidence of fracture or subluxation. There were 4 to 5 mm broad based disc protrusions at L4-5 and L5-S1 indenting the thecal sac and bilateral emergent nerve roots. There was moderate to severe bilateral foraminal and lateral recess narrowing. Electro diagnostic studies on 02/10/2014 revealed evidence of very mild chronic S1 radiculopathy on the left side. Nerve conduction studies demonstrated no evidence of peripheral neuropathy or abnormalities from nerve root impingement. On a preoperative risk assessment on 05/14/2014, it was noted that further testing was needed before the requested surgery could be approved. The requested test results were not included for review. The rationale for the requested surgery was that it would help decompress his impinged nerves, which were believed to cause his S1 radicular pain. A Request for Authorization with an incorrect date of 03/14/2015 was included in this workers' chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intraoperative neuromonitoring: 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), Low Back - Lumbar & Thoracic, Intraoperative neurophysiological monitoring (during surgery).

Decision rationale: Recommended 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. 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. Use of intraoperative SSEP (somatosensory evoked potential) or DSEP (dermatomal sensory evoked potential) monitoring is recommended as an adjunct in those circumstances during instrumented lumbar spinal fusion procedures in which the surgeon desires immediate intraoperative information regarding the potential of a neurological injury. The requested surgery stipulates that it is a minimally invasive procedure, which would not put it into the "risk of significant complications" category. It is not a lumbar spinal fusion. The type of Intraoperative Neuromonitoring was not specified. Therefore, this request for Intraoperative Neuromonitoring is not medically necessary.

2-3 day inpatient stay: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (<http://www.odg-twc.com/bp/722.1>)

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, Hospital length of stay (LOS).

Decision rationale: The request for a 2-3 day inpatient stay is not medically necessary. The Official Disability Guidelines' hospital length of stay guidelines for laminectomy state that best practice is 1 day. The requested 2 to 3 days exceeds the recommendations in the guidelines. Therefore, this request for 2-3 day inpatient stay is not medically necessary.