

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

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

This patient is a 70-year-old female who reported an injury on 10/04/2010. Under consideration is a prospective request for certification of 1 lumbar spine consultation. The documentation submitted for review indicates that this patient has a history of cervical, thoracic, and lumbar spine pain. Notes indicate that the patient has undergone imaging of the cervical spine with MRI revealing a 2.5 mm degenerative anterolisthesis at C2-4 with mild reversal of the normal cervical curve, spinal stenosis at C3-4 of severe nature on the right and moderate left, C4-5 with a 7 mm central canal stenosis causing mild cord compression and severe right and moderate left neural foraminal stenosis, C5-6 with a 6 mm central canals stenosis due to 4 mm posterolateral protrusion causing mild cord compression, moderate right and severe left neural foraminal stenosis, C6-7 8.5 mm central canal stenosis with a 3.3 mm disc bulge and posterior osteophytes with moderate bilateral neural foraminal stenosis. An MRI of the lumbar spine was completed on 10/19/2010 revealing L4-5 degenerative spondylolisthesis with multifactorial severe central canal stenosis and L4-5 right paracentral focal disc protrusion with facet degenerative changes resulting in multifactorial mild canal stenosis right lateral recess stenosis and presumably impinging on the right S1 nerve root, as well as some mild right neural foraminal stenosis. An MRI of the lumbar spine was completed on 03/28/2011, noting normal findings. This patient also underwent electrodiagnostic studies on 11/15/2011 revealing decreased median motor amplitude, with an otherwise normal NCV and EMG showing chronic lower cervical spondylosis with no evidence of denervation. Physical therapy notes indicate the patient to have undergone an unknown number of sessions of physical therapy, as well as clinical notes indicating that the patient has undergone pool therapy, massage therapy, and possibly acupuncture treatment. Clinical notes from 01/15/2013 indicated the patient to be having severe migraine headaches with objective evaluation of the patient noting that the range of motion of the neck with flexion, extension, and lateral bending bilaterally, as well as rotation bilaterally being at 25%, decreased from normal value. Clinical notes from 03/25/2013 indicated a continuing worsening of pain in the low back and neck with objective evaluation of the cervical spine showing loss of normal lordosis with osteophytes and narrowing as well. Also noted is a review of the patient's MRI of the lumbar spine from 2011 noting fairly significant stenosis of

the lumbar spine at L4-5. Clinical notes from 05/13/2013 indicate the patient was seen in consultation for a neurosurgical examination. Notes indicated the patient to have moderate to severe spondylotic cord impingement at multiple levels with pain verbalized as 6/10 in intensity. Notes indicate the patient was utilizing Xanax and Norco and that the patient's pain was 60% in her neck and 40% in her arms. Notes indicate the patient described an electric shooting pain into the right arm, wrist, fingers, hands, forearms, and shoulders, with the patient indicating a "blocked feeling" in the neck, indicating that she could not extend the neck. Notes indicate the patient to have headaches and inability to turn the head to the right. Notes indicated that as of 05/13/2013 the patient had completed 6 sessions of physical therapy with pool therapy and that the patient had undergone trials of acupuncture. Physical examination of the patient noted severe decrease in range of motion of the cervical spine in all planes with positive findings for Lhermitte's type pain in the scapular region and Spurling's sign over the deltoid. Notes indicated the patient has wished to pursue nonsurgical treatment and recommendation was made for further physical therapy, as well as epidural steroid injection, and flexion and extension views of the cervical spine, as well as electrodiagnostic testing, and a lumbar spine consultation.

IMR DECISION(S) AND RATIONALE(S)

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

1. Lumbar Spine Consultation is not medically necessary and appropriate.

The Claims Administrator guidelines are unclear based on the utilization review determination.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition (2004), Chapter 12, page 305, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS/ACOEM Guidelines indicate that surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair; and for those with failure of conservative treatment to resolve disabling radicular symptoms. The documentation submitted for review indicates the patient to have fairly significant stenosis at L4-5 in the lumbar spine, with subjective complaints of the patient of back pain with evidence on exam of loss of lordosis and guarding. Reflexes of the knees were 1 and symmetrical with trace reflexes noted in the ankles and the plantar reflexes noted to be flexor. Motor strength was 5/5 and sensory examination was noted to be normal as of evaluation on 05/13/2013. While notes indicate the recommendation for a lumbar spine consultation, there is a lack of sufficient findings noted on examination of the patient indicating a neuropathology. Notes indicate the patient had motor function of 5/5 with a normal sensory examination. Furthermore, notes indicate that the patient wishes to pursue nonsurgical treatment for her neck and back complaints, therefore, it is unclear the benefit of a further spine consultation in regards to the patient's treatment plan. Given the above, the request for lumbar spine consultation is not medically necessary and appropriate.

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