

Case Number:	CM13-0016126		
Date Assigned:	03/12/2014	Date of Injury:	05/06/2007
Decision Date:	09/30/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	08/26/2013

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 Orthopedic Surgery and Hand 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 claimant is a 46-year-old gentleman who injured his low back in a work related accident on May 6, 2007. The clinical records provided for review document that the claimant has been treated conservatively with no significant improvement for a current diagnosis of chronic low back pain. It was documented that conservative treatment consisted of physical therapy, activity modification, epidural injections, facet joint injections and pain management. The report of a December 3, 2012 MRI showed disc degeneration at L4-5 and L5-S1 with a 3 millimeter posterior disc protrusion at L5-S1 encroaching the foramina and abutting the exiting left S1 nerve root. Electrodiagnostic studies performed on January 8, 2013 revealed no acute radiculopathy. The report of a follow up visit dated July 22, 2013 revealed continued complaints of low back pain and physical examination showed motor strength at 3+/5 bilaterally and subjective dragging of the foot. Recommendations at that time included updated neurodiagnostic studies as well as operative intervention of an L4 through S1 posterior lumbar interbody fusion. No further imaging reports were available for review. A follow up report dated August 19, 2013 showed similar physical examination findings, but no documentation of additional diagnostic evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4 TO S1 POSTERIOR LUMBAR INTERBODY FUSION WITH INSTRUMENTATION, NEURAL DECOMPRESSION, AND ILIAC CREST MARROW ASPIRATION/HARVESTING, AND POSSIBLE JUNCTIONAL LEVELS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

Decision rationale: Based on the California ACOEM Guidelines, the request for L4-S1 posterior lumbar interbody fusion is not recommended as medically necessary. According to the ACOEM Guidelines, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. The medical records do not contain any imaging or evidence of instability at the L4-5 or L5-S1 level. It does not appear by the records that the claimant has had any recent conservative care, updated imaging or positive electrodiagnostic studies. While the claimant is noted to have weakness noted on examination, the lack of instability or compressive pathology at the two requested surgical levels on MRI or electrodiagnostic studies would fail to acutely support the role of surgical intervention.

FRONT WHEEL WALKER, ICE UNIT, BONE STIMULATOR, TLSO, AND 3-IN1 COMMODORE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 13, 337-339, 9, 298, 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: knee procedure - Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot orthoses are superior to flat inserts for

patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful Walking aids (canes, crutches, braces, orthoses, & walkers) not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. Cane use, in conjunction with a slow walking speed, lowers the ground reaction force, and decreases the biomechanical load experienced by the lower limb. The use of a cane and walking slowly could be simple and effective intervention strategies for patients with OA. In a similar manner to which cane use unloads the limb, weight loss also decreases load in the limb to a certain extent and should be considered as a long-term strategy, especially for overweight individuals. (Reeves, 2011) Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: low back procedure – Bone growth stimulators (BGS) Under study. There is conflicting evidence, so case by case recommendations are necessary (some RCTs with efficacy for high risk cases). Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, smoker). (Mooney, 1990) (Marks, 2000) (Akai, 2002) (Simmons, 2004) There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at "high risk", but this has not been convincingly demonstrated. (Resnick, 2005) Also see Fusion for limited number of indications for spinal fusion surgery. See Knee & Leg Chapter for more information on use of Bone-growth stimulators for long bone fractures, where they are recommended for certain conditions. Criteria for use for invasive or non-invasive electrical bone growth stimulators: Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s) (2) Grade III or worse spondylolisthesis (3) Fusion to be performed at more than one level (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor) (5) Diabetes, Renal disease, Alcoholism (6) Significant osteoporosis which has been demonstrated on radiographs. (Kucharzyk, 1999) (Rogozinski, 1996) (Hodges, 2003).

Decision rationale: The proposed L4-S1 posterior lumbar interbody fusion is not recommended as medically necessary. Therefore, the requests for the postoperative use of a wheeled walker, cryotherapy device, bone growth stimulator, brace, or three-in-one commode is also not recommended as medically necessary.

MEDICAL CLEARANCE: 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 American College of Occupational and Environmental

Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 Independent Medical Examinations and Consultations, page 127.

Decision rationale: The proposed L4-S1 posterior lumbar interbody fusion is not recommended as medically necessary. Therefore, the request for preoperative medical clearance is also not medically necessary.