

<b>Case Number:</b>	CM13-0069452		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	09/06/2011
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2013

### 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 and is licensed to practice in Arizona. 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 60-year-old female presents with low back pain [visual analog scale (VAS) scale at 5/10] and bilateral leg pain [right more than left] since September 4, 2011. She was employed as a care-giver by [REDACTED] [the previous 5 years] and was assisting a patient to transfer, when she experienced the low back and right leg pain. She describes the low back pain as more severe. Her symptoms started on September 4, 2011 and subsequently saw her physician on February 14, 2012 [no report of clinical findings or treatment rendered during the interim time period available]. Currently, on October 15, 2013, she complains of moderate back, bilateral buttock and bilateral post thigh pain of 5/10 intensity on pain diagram. She cannot walk more than 100 yards [pain intensifies], or standing more than 10 minutes. She continues to work 4 hours per day. She is diabetic and is receiving Metformin. Conventional non-surgical treatment has been unsuccessful and her status has not improved in 6 months. Physical examination revealed findings compatible with L4-5 lumbar spinal stenosis. Sensation was decreased over lateral right thigh, motor strength lower extremities was intact, Deep tendon reflexes were absent in both legs. Treatment rendered since day of onset included medications [Tramadol, Motrin, Gabapentin, and Aspirin], Physiotherapy [including home exercise program], Chiropractic, several facet injections [denied eventually] and epidural injections. Above treatment regime, up to this time, has been unsuccessful. Diagnostic studies consisted of lumbar MRI [12/01/2011], repeat lumbar MRI w/o contrast [7/19/2013] and plain X-ray [10/15/2013] including flexion-extension views showing instability at L4-5. Diagnosis was documented as Gr I Spondylolisthesis L4-5, fairly severe central stenosis with neural foraminal stenosis, right more severe than left. Recommendations: Lumbar surgery consisting of laminectomy decompression at level L4-5. I presume spinal stabilization will be decided on basis of integrity of facet joints after decompression. Axial views of the L4-5 facet joints were not available to judge if more

than 50 % of the L4-5 joint will need to be excised for adequate decompression. This procedure was approved as medically necessary on 11/26/2013. The approval is for 1 day hospital stay and routine pre-operative tests.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **LUMBAR BACK BRACE:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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, Laminectomy, Post-operative fusion Insert Section >, <Post-operative bracing>.

**Decision rationale:** No guidelines regarding usage of lumbar brace after lumbar decompression or fusion was found in A.C.O.E.M. or M.T.U.S. The O.D.G. indicated that this issue is under study and due to present conflicting evidence; each case should be assessed individually. Per definition, post-operative braces are external devices that support the spine. The soft lumbar corset is used primarily for muscular support in the low back. A lumbar corset is used for individuals who have extensive arthritis, mild instability of the lumbar spine and post-operative after relative minor surgery. The additional support offers relief of patient's post-operative low back pain. The corset may also act as a reminder to avoid excessive low back motion and may help to encourage proper body mechanics. From a scientific point of view, bracing is not essential for a favorable outcome but in this patient's case, using a case by case principle in the present absence of adequate outcome studies available, this patient should be given the usage of a standard soft brace for the following reasons:-This elderly lady will experience more comfort and less post-operative pain by using a soft [standard] brace. This aspect will hopefully be included in future R.C.T. [Randomized Controlled Trials] criteria.-Even assuming that she has no osteoporosis [unlikely] , after decompression surgery the residual facet joint is in jeopardy of fracture and subsequent further instability [Abumi 1990] [Grobler 1993].-Concerns that excessive use of such a corset might weaken the lumbar muscles are valid but only if she uses the brace constantly, this could occur. For this reason it is recommended not to use the brace continuously. Rather, use it in a "task specific" manner. The brace should be employed when she is involved in activities that place her back at risk. When this "at risk" activity is finished, the brace should be removed. Bracing should also be done in conjunction with a lumbar strengthening exercise program as instructed. Ideally, the lumbar strengthening exercise program will increase muscle strength. Unfortunately, such a program takes time to have this effect. The brace can assist in supporting the spine until muscle strength is adequate. -If at the time of surgery a spinal fusion is deemed necessary, a customized, molded Orthosis may then be needed especially if non-instrumented fusion is done. Diabetics also have a lower rate of fusion and any additional support will assist in bony fusion. -As I do not see spinal fusion as a question on the table, I will not further comment.-The long-term randomized prospective data that are required to accurately weigh the risks and benefits of lumbar bracing after surgery will not be available for a long time. Until these long-term data are available, it is difficult to justify widespread usage of

post-operative bracing and should be reserved for use 'on a case by case basis'. It is medically necessary for a post-operative lumbar brace for this patient partly based on above points and also in absence of harm reported in the literature and lastly what is presently the 'standard of care' is awaiting clinical research to clarify this issue.