

Case Number:	CM14-0069658		
Date Assigned:	07/16/2014	Date of Injury:	11/27/2009
Decision Date:	08/14/2014	UR Denial Date:	04/25/2014
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 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 patient is a 53 year old female who was injured on 11/27/2009, when she hit her head on the doorframe upon entering her truck. She underwent anterior cervical discectomy and fusion with instrumentation on 6/6/2010. She also complained of low back pain radiating to the bilateral lower extremities. Treatment has included medications, physical therapy (PT), acupuncture, chiropractic and epidural injection. According to the orthopedic agreed medical examination on 9/11/2012, the patient was noted to be an active cigarette smoker of one pack every 3-4 days. According to the 4/8/2014 progress report, the patient continued with pain down the lower extremities, worse on the right. Examination revealed antalgic gait, pain with range of motion, straight leg raise positive in the right lower extremity, and decreased sensation in right L4 distribution. The 4-view lumbar radiographs reported to reveal worsening of spondylolisthesis at L5-S1. Assessment is mostly mild spondylolisthesis at L4-5 and significant progression of instability at L5-S1, when compared to the 2011 x-ray. An updated lumbar MRI was requested. Proceeding with the surgery was recommended. An updated lumbar spine MRI study performed on 5/29/2014 with comparison to 4/18/2014 plain films. The study provided the impression: L3-L4: Moderate loss of disc space height, mild disc desiccation, and a 2 mm posterior broad-based disc bulge causes mild central canal narrowing and mild bilateral neural foraminal narrowing. L4-L5: Mild disc desiccation and a 2 mm disc bulge is eccentric towards the inferior recesses of the bilateral neural foramina which are mildly narrowed. Mild bilateral facet arthropathy is present, left, is greater than the right. The disc abuts and minimally effaces the ventral margin of the thecal sac. Ligamentum flavum hypertrophy is also present which effaces the dorsal margins of the thecal sac. Mild central canal stenosis is present. L5-S1: Moderate disc desiccation and a 3 mm spondylolisthesis is present resulting in dorsal uncovering of the disc. Moderate bilateral facet arthropathy is present. Synovial fluid lines both facet joints. Moderate bilateral neural

foraminal stenosis is present and there is abutment of the right and encroachment on the left foraminal L5 nerves. A 4 mm synovial cyst arises from the dorsal margin of the left facet joint. The patient was re-evaluated on 7/1/2014. Physical examination showed antalgic gait, increase pain on range of motion, straight leg raise in the right lower extremity, and decreased sensation in the right L4 distribution. X-ray and MRI findings are reviewed. She has had physical therapy, chiropractic, acupuncture, and epidural. The assessment is she can live with the pain versus surgery. Recommendation is for laminectomy and posterior spinal fusion with instrumentation and lateral interbody fusion at L4-5 and L5-S1 levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative Front Wheeled Walker: 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, Fusion (spinal); Knee and Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: According to the ODG, disability, pain, and age-related impairments seem to determine the need for a walking aid. The medical records document L4-5 and L5-S1 spondylolisthesis, progressed as worse at the L5-S1 level. In which case spinal fusion may be an option. However, the medical records do not establish the pre-surgical indicators have been addressed as recommended under the guidelines. The medical records document the patient is an active cigarette smoker, and there is no documented evidence of smoking cessation. In addition, there is no evidence of her having undergone a psychiatric clearance. Consequently, the medical records do not establish this patient is currently a viable candidate for multilevel lumbar fusion. In the absence of surgical intervention, a post-operative front wheeled walker is not medically necessary.