

Case Number:	CM13-0010217		
Date Assigned:	11/27/2013	Date of Injury:	06/19/2013
Decision Date:	03/04/2014	UR Denial Date:	07/17/2013
Priority:	Standard	Application Received:	08/16/2013

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 New Hampshire, New York and Washington. 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. 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 38-year-old male who injured his back while working as an assistant mechanic on June 19, 2013. The patient sustained a T12 compression fracture. The patient presented to the hospital without neurologic deficit, and the evaluation at the hospital indicate that the fracture is stable. The imaging studies to include CAT scan and MRI from the hospital also indicate that the fracture is stable. The patient complains of chronic thoracic back pain. The patient feels that his back pain inhibits his pain of life and performance of physical activity and activities of daily living. A physical exam demonstrates tenderness to palpation as well as muscle spasms in the region of the fracture. There is no neurologic deficit noted on physical examination. A CAT scan showed 30% fracture. X-rays on June 20, 2013 showed 50% collapse of vertebral body. Repeat x-rays show 50% compression of vertebral body. X-rays show kyphosis of the spine with suggested abnormal sagittal and coronal alignment. The degree of kyphosis and abnormal alignment is not mentioned by the treating physician. Initial records from the hospital do not document abnormal alignment. The patient has been treated with bracing. An MRI of the lumbar spine shows stable burst fracture with intact posterior elements and no edema in the posterior elements. CAT scan showed intact posterior spinal elements. At issue is whether T11, T12, and L1 posterior fusion surgery along with T12 kyphoplasty is medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

T11-L1 posterior fusion and T12 kyphoplasty with small BMP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation "Measuring the impact of the Thoracolumbar Injury Classification and Severity Score among 458 consecutively treated patients." By Joaquim AF, Lawrence B, Daubs M, Brodke D, Tedeschi H, Vaccaro AR, Patel AA in the Journal of Spinal Cord Medicine. 2014 Jan;37(1):101

Decision rationale: Surgical stabilization of this patient's stable T12 burst fracture is not medically necessary. The CAT scan and the MRI of the thoracic spine and lumbar spine do not demonstrate any evidence of posterior bony or ligamentous injury. The patient does not have a documented neurologic deficit. This patient has a stable T12 fracture which is documented in the hospitalization records. Current medical literature clearly describes successfully treating this fracture without surgery. There is no medical literature that recommends surgical treatment for fractures with 50% loss of vertebral body height and intact posterior elements along with a normal neurologic exam. Multiple published peer-reviewed medical studies demonstrate that this patient has a stable fracture that is safely and effectively managed nonoperatively with very good functional outcomes. There is no documentation in the medical records of excessive kyphosis of posterior ligamentous injury. While the surgeon mentions collapse of the vertebral body, he does not quantify the amount of kyphosis present. Additionally, the patient remains neurologically normal. The TLICS classification and treatment recommendations for lumbar and thoracic fractures was recently published by the spinal trauma study group. This patient's fracture is clearly a TLICS score #2 and surgery is not recommended for this fracture based on the findings of the research performed then published by the spine trauma study group. Additionally, there is no role for kyphoplasty in the stable burst fracture. Recent medical literature has demonstrated kyphoplasty no more than she treatment. In addition kyphoplasty is contraindicated in burst fracture morphology pieces with a posterior wall vertebral he has been fractured as there is a high incidence of cement leakage into the spinal canal. Posterior spinal fusion and kyphoplasty is not medically necessary for this patient with stable T12 burst fracture.