

<b>Case Number:</b>	CM14-0011181		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	12/27/1995
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	01/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2014

### 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 Occupational Medicine 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:

This is a 61 year old male with a 12/27/95 date of injury. The patient was diagnosed with a compression fracture at L1 and had an intrathecal pain pump (ICP) placed in 2012. A vertebroplasty at L1 was requested at that time but denied given there were no plain films to show a greater than 30% loss in vertebral height and no discussion of care of the vertebral fracture. The patient was seen on 1/07/14 (progress note was handwritten and illegible) with low back complaints radiating to the legs right greater than left, 6/10. A CT of the L spine on 3/18/11 revealed marked multilevel chronic decompression deformities greater at L1 (report not available for review). A Bone Scan on 4/29/11 was consistent with decompression deformity at L1 of intermediate age as described on CT (report not available for review). Exam findings revealed antalgic posture. His ICP was noted to be providing excellent pain relief. The request was for an intrathecal pain pump (ICP) replacement with X ray needle localization under fluoroscopy and a verteberoplasty at L1. The ICP replacement under fluoroscopy was certified. The diagnosis is postlaminectomy syndrome. Treatment to date: ICP, medications, surgery, A UR decision dated 1/21/14 denied the request for X ray needle localization given there is no need for that procedure when implanting an intrathecal pain pump and fluoroscopy was sufficient to show localization of the pain pump. The request for an L1 vertebroplasty was denied given ODG does not support vertebroplasty for the treatment of a compression fracture.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-RAY (NEEDLE LOCALIZATION):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Intrathecal pain pump Page(s): 52-53.

**Decision rationale:** CA MTUS states that intrathecal morphine may be indicated following failure of at least 6 months of other conservative treatment modalities, intractable pain secondary to a disease state with objective documentation of pathology, further surgical intervention is not indicated, psychological evaluation unequivocally states that the pain is not psychological in origin, and a temporary trial has been successful prior to permanent implantation as defined by a 50% reduction in pain. This patient is noted to have a pain pump in place, which is providing excellent pain relief. In addition, a replacement device under fluoroscopy was certified, hence it is unclear why an X-ray needle localization is necessary. Therefore, the request for X-ray needle localization was not medically necessary.

**VERTEBROPLASTY AT L1:** 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 CHAPTER-VERTEBROPLASTY.

**Decision rationale:** CA MTUS does not address this issue. Per ODG this procedure is not recommended based on recent higher quality studies. Although it may be an option to treat multiple myeloma (MML) patients with nonosteoporotic vertebral compression fractures, the symptomatic benefits of vertebroplasty are controversial. In addition, the progress notes are scant with regard to physical exam findings, and there are no radiologic reports available for review to confirm a vertebral height loss of 30% at L1. The patient has been stable and there is no documentation of imaging being done since 2011 with regard to the lumbar spine. It is also unclear why a balloon kyphoplasty or other procedures which has demonstrated greater efficacy in cases of compression fractures with vertebral height loss have not been discussed in this patient. Therefore, the request for a Vertebroplasty at L1 was not medically necessary.