

<b>Case Number:</b>	CM14-0121596		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	12/03/2001
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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 Texas. 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 injured worker is a 62 year old male who had a work related injury on 12/03/2001. The mechanism of injury is not documented. The most recent clinical note submitted for review is dated 06/04/14. The injured worker was seen for flare up of mid and low back pain. He has had thoracic spine x-rays and a lumbar spine magnetic resonance image since he was last seen. Apparently he had a fall on 03/31/14, his primary care provider started him on Flexeril for acute flare ups of muscle spasm and Norco for severe pain. He complained of having increased jaw pain and he thinks it is due to his amyotrophic lateral sclerosis,. The injured worker has undergone multiple tests which determined that he has amyotrophic lateral sclerosis,. Pain is described as achy, burning, and stabbing in the right shoulder and low back. He rates his pain as 6/10 in intensity without pain medication and 4/10 with pain medication. Pain is unchanged since his last visit. No new symptoms or neurologic changes are noted. He continues to use his transcutaneous electrical nerve stimulation unit, massage chair and back brace. Physical examination noted 5-/5 bilateral lower extremities strength. Patellar deep tendon reflexes are 2+. Achilles deep tendon reflexes are 1+. Sensation is intact. There is no clonus or increased tone. Babinskis are plantar bilaterally. Sciatic notches are pain free to palpation. There is tenderness to palpation of the thoracic spine at T1-2. There is tenderness over the lumbar paraspinals. There is pain with lumbar extension and flexion. Straight leg raising elicits low back pain. Positive atrophy of the bilateral lower extremities. Normal heel and toe gait. Lumbar spine magnetic resonance image done on 05/29/14 notes acute to subacute moderate anterior compression fracture of T12, no significant bony retropulsion. Chronic mild compression fracture of L5. Impression is acute subacute moderate anterior compression fracture at T12, consider vertebroplasty for pain management if clinically indicated. Chronic mild compression deformity of the L5 vertebral body. Stable mild multilevel degenerative spondylosis without

significant canal stenosis at any level. Prior utilization review on 07/29/14 was denied. There has been no documentation of collapse of the fracture at T12.

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

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

#### **Vertebroplasty of T12: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter.

**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:** The request Vertebroplasty of T12 is not medically necessary. Criteria for percutaneous vertebroplasty (while Not recommended in Official Disability Guidelines) is severe debilitating pain or loss of mobility that cannot be relieved by correct medical therapy, other causes of pain, such as herniated intervertebral disk have been ruled out by computed tomography or magnetic resonance imaging and that the affected vertebra has not been extensively destroyed and is at least one third of its original height. As such, the request is not medically necessary and appropriate.