

<b>Case Number:</b>	CM14-0030123		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	12/27/1995
<b>Decision Date:</b>	08/04/2014	<b>UR Denial Date:</b>	02/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2014

### 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, Montana and Tennessee. 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 60-year-old male who reported an injury on 12/27/1995. The mechanism of injury was not stated. Current diagnoses include low back pain and failed back surgery syndrome. The patient was evaluated on 02/04/2014 with complaints of lower back pain. It is noted that the injured worker has been previously treated with medication management and intrathecal pump implantation. The injured worker is also status post lumbar fusion. Physical examination revealed a markedly antalgic posture and severe pain secondary to motion. Treatment recommendations at that time included a consideration for L1 vertebroplasty and sacroplasty. A Request for Authorization Form was then submitted on 02/05/2014 for a vertebroplasty/kyphoplasty.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Vertebroplasty L1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 12th Edition, 2014, Low Back Chapter, Vertebroplasty.

**MAXIMUS 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, Vertebroplasty.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms, activity limitation for more than 1 month, clear clinical, imaging, and electrophysiologic evidence of a lesion, and failure of conservative treatment. The Official Disability Guidelines state vertebroplasty is not recommended based on recent higher quality studies. While not recommended, criteria includes severe debilitating pain or loss of motion, exclusion of other causes of pain such as herniated intervertebral disc, and evidence of at least one third of the original height at the affected vertebra. As per the documentation submitted, the injured worker's physical examination on the requesting date only revealed a markedly antalgic posture with painful range of motion. There were no plain films obtained prior to the request for a vertebroplasty. There is no mention of an exclusion of other causes of pain such as a herniated disc. Based on the clinical information received, the request for Vertebroplasty L1 is not medically necessary and appropriate.

**Vertebroplasty L3 and sacral ala, Qty: 2: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 12th Edition, 2014, Low Back Chapter, Vertebroplasty.

**MAXIMUS 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, Vertebroplasty.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms, activity limitation for more than 1 month, clear clinical, imaging, and electrophysiologic evidence of a lesion, and failure of conservative treatment. Official Disability Guidelines state vertebroplasty is not recommended based on recent higher quality studies. While not recommended, criteria includes severe debilitating pain or loss of motion, exclusion of other causes of pain such as herniated intervertebral disc, and evidence of at least one third of the original height at the affected vertebra. As per the documentation submitted, the injured worker's physical examination on the requesting date only revealed a markedly antalgic posture with painful range of motion. There were no plain films obtained prior to the request for a vertebroplasty. There is no mention of an exclusion of other causes of pain such as a herniated disc. Based on the clinical information received, the request for Vertebroplasty L3 and sacral ala, quantity 2 are not medically necessary and appropriate.

**Percutaneous vertebral augmentation, QTY: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 12th Edition, 2014, Low Back Chapter, Vertebroplasty.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms, activity limitation for more than 1 month, clear clinical, imaging, and electrophysiologic evidence of a lesion, and failure of conservative treatment. Official Disability Guidelines state vertebroplasty is not recommended based on recent higher quality studies. While not recommended, criteria includes severe debilitating pain or loss of motion, exclusion of other causes of pain such as herniated intervertebral disc, and evidence of at least one third of the original height at the affected vertebra. As per the documentation submitted, the injured worker's physical examination on the requesting date only revealed a markedly antalgic posture with painful range of motion. There were no plain films obtained prior to the request for a vertebroplasty. There is no mention of an exclusion of other causes of pain such as a herniated disc. Based on the clinical information received, the request is non-certified.

**Percutaneous vertebral augmentation, QTY: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 12th Edition, 2014, Low Back Chapter, Vertebroplasty.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms, activity limitation for more than 1 month, clear clinical, imaging, and electrophysiologic evidence of a lesion, and failure of conservative treatment. Official Disability Guidelines state vertebroplasty is not recommended based on recent higher quality studies. While not recommended, criteria includes severe debilitating pain or loss of motion, exclusion of other causes of pain such as herniated intervertebral disc, and evidence of at least one third of the original height at the affected vertebra. As per the documentation submitted, the injured worker's physical examination on the requesting date only revealed a markedly antalgic posture with painful range of motion. There were no plain films obtained prior to the request for a vertebroplasty. There is no mention of an exclusion of other causes of pain such as a herniated disc. Based on the clinical information received, the request for percutaneous vertebral augmentation, quantity 1 is not medically necessary and appropriate.

**Fluoroscopy, QTY: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 12th Edition, 2014, Low Back Chapter, Vertebroplasty.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the

associated services are medically necessary.

**Needle localization by x-ray, qty:1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 12th Edition, 2014, Low Back Chapter, Vertebroplasty.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.