

<b>Case Number:</b>	CM14-0119674		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	03/26/2014
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	07/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2014

### 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 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 claimant is a 46-year-old helicopter pilot who sustained an industrial related injury on March 26, 2014 injuring his back. Radiographs disclosed a fracture of T11. The patient was treated in a TLSO brace. The patient developed complaints of mid and low back pain with limited motion of the thoracic and lumbar spine with pain. A progressive gibbus deformity was noted. On April 10, 2014, CT and MRI scan showed a compression fracture T11 with 50% reduction of height. Exam note May 22, 2014 demonstrated further compression. Radiographs from July 7, 2014 demonstrated a small anterior osteophyte at L5 and transitional lumbarized S1 vertebra. A request was made for left-sided T10-T11 direct lateral interbody fusion with correction of kyphosis and posterior pedicle screws T9, T10, T11, and T12 with an anterior lumbar interbody fusion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Sided T10-T11 Direct Lateral Interbody Fusion with Correction of Kyphosis and Posterior Pedicle Screws T9, T10, T11, And T12 with Anterior Lumbar Interbody Fusion at L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back Procedure Summary last update 07/03/2014, Low Back Spinal Fusion

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Fusion (spinal)

**Decision rationale:** The ACOEM Guidelines Chapter 12 Low Back Complaints page 307 state that lumbar fusion, "Except for cases of trauma-related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." According to the Official Disability Guidelines, low back, fusion (spinal) should be considered for 6 months of symptoms. Indications for fusion include neural arch defect, segmental instability with movement of more than 4.5 mm, revision surgery where functional gains are anticipated, infection, tumor, deformity and after a third disc herniation. In addition, Official Disability Guidelines states, there is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-operative, total disability over 6 months, active psych diagnosis, and narcotic dependence. In this particular patient there is lack of medical necessity for lumbar fusion at L5/S1 as there is no evidence of segmental instability greater than 4.5 mm or psychiatric clearance to warrant fusion at L5/S1. Therefore, this request is not medically necessary.

**S35 Spinal Q Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back Procedure Summary last updated 12/27/2013

**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.

**Ultram 50mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**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.

**Fentanyl 12mcg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system). Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG)-TWC Pain Procedure Summary last updated 06/10/2014  
Duragesic/Fentanyl Transdermal System

**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.

**Restoril 30mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

**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.