

Case Number:	CM15-0114421		
Date Assigned:	06/22/2015	Date of Injury:	01/28/2015
Decision Date:	07/23/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Neurological Surgery

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 51-year-old female, with a reported date of injury of 01/28/2015. She had chronic thoracic spine pain since a slip and fall down the stairs. The diagnoses include thoracic sprain/strain. Treatments to date have included an MRI of the thoracic spine on 03/12/2015 which showed compression fractures, and a mild degree of decreased signal intensity compatible with desiccation; an x-ray of the thoracic spine on 01/28/2015 which showed compression fractures at T5, T6, T7, and T8 areas; oral medications; and physical therapy. The initial orthopaedic consultation dated 05/07/2015 indicates that the injured worker complained of upper back pain and mid back pain, which was rated 8 out of 10. It was noted that she was unable to do anything, and had not been able to work. There was no numbness or tingling in her arms or hands. The conservative treatments were not helping. The physical examination showed pain, difficulty bending or twisting of the spine, severe tenderness to palpation in the mid thoracic spine area, and tenderness to percussion as well. The treating physician recommended kyphoplasty for pain control. The treating physician requested Kyphoplasty at T5, T6, and T8 with fluoroscopy, a lumbar corset, home health physical therapy three times a week for three weeks, and post-operative physical therapy two times a week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kyphoplasty T5, T6, T8 with fluoroscopy (Kyphon equipment by [REDACTED]): 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-180.

Decision rationale: The California MTUS guidelines recommend cervical surgery when the patient has had severe persistent, debilitating, upper extremity complaints referable to a specific nerve root or spinal cord level corroborated by clear imaging, clinical examination and electrophysiological studies. Documentation shows the presence of cervical compression fractures not thoracic per the request. The guidelines note the patient would have failed a trial of conservative therapy. The guidelines note the surgical repair proposed for the lesion must have evidence of efficacy both in the short and long term. Therefore, the request for Kyphoplasty T5, T6, T8 with fluoroscopy (Kyphon equipment by [REDACTED]) is not medically necessary and appropriate.

Associated surgical service: Lumbar corset: Upheld

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

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.

Associated surgical service: Home health physical therapy 3x3 weeks: Upheld

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

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.

Post-operative physical therapy 2x4 weeks: Upheld

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

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.