RyCo MedReview
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Notice of Independent Review Decision

DATE OF REVIEW: 03/04/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Kyphoplasty Outpatient 22523 22525 Thoracic

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Kyphoplasty Outpatient 22523 22525 Thoracic - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Special Procedures Kyphoplasty/Vertebroplasty Referral, M.D., 01/06/08
- Preliminary Radiology Report, M.D., 08/31/08

- Progress Notes, 09/02/08, 09/04/08, 09/09/08, 09/10/08, 09/16/08, 09/23/08, 10/01/08, 10/14/08, 10/28/08, 11/10/08, 11/24/08, 12/29/08
- DWC-73, Dr. 09/02/08, 09/09/08, 09/16/08, 09/23/08, 10/01/08, 10/14/08, 10/28/08, 11/10/08, 11/24/08, 12/29/08
- Letter to Dr. 09/08/08, 10/13/08
- MRI of the Lumbar Spine Without Contrast, M.D., 09/09/08
- MRI of the Thoracic Spine Without Contrast, Dr. 09/09/08
- Prescription, Dr. 09/10/08
- Physical Capabilities For the Workplace, Dr. 09/10/08, 09/29/08, 10/13/08
- Hospital Confinement Claim Form, 09/12/08
- Recommendation for an FCE, Dr. 10/14/08
- Recommendation for PT/FCE, Dr. 10/27/08
- Examination Evaluation, M.D., 12/08/08
- Appointment Letter, Family Medical Center 12/30/08
- Interventional Radiology Consult, M.D., 01/06/09
- MRI of the Lumbar Spine (Without Contrast), MRI, 01/08/09
- Prescription, Dr. 01/08/09
- Two Views of the Thoracolumbar Spine Series, Dr. 01/09/09
- Adverse Determination, 01/12/09
- Acknowledgement of Reconsideration Request, 01/22/09
- Notification of Reconsideration Determination, 01/29/09
- DWC-73, Dr. (No date)
- Workers Comp Information sheet (No date)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained an injury to his back on xx/xx/xx when he fell from a ladder approximately five feet. Multiple MRI's were performed and his most recent medications were noted to be Carisoprodol and Vicodin.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The reviewer finds that the previous adverse determination should be upheld. The rationale is the ODG criteria for kyphoplasty which includes:

Presence of unremitting pain and functional deficits due to compression fracture from osteolytic metastasis, myeloma, hemangioma, and osteoporotic compression fractures.

Lack of satisfactory improvement with medical treatment (e.g., medication, bracing therapy).

Absence of alternative causes of pain such as herniated intervertebral disc.

The affected vertebra is at least one third of its original height. As noted on the two MRIs, the most ever noted was 25% on 09/09/08 and it was 20% on 01/08/09. The patient does not meet the ODG criteria due to the lack of severity of the compression fracture.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM - AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR - AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**