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Notice of Independent Review Decision

DATE OF REVIEW: April 26, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Osteoplasty at L4 (22521 and 95920)

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

Certified, American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits (11/19/09 - 01/19/10)
- Diagnostic studies (12/09/09 – 01/14/10)
- DWC-73 (01/12/10 - 11/19/09)

- Office visits (12/07/09 – 03/30/10)
- Diagnostic studies (12/09/09 – 01/28/10)
- Peer review (01/26/10)
- Utilization reviews (01/27/10 – 03/08/10)

- Utilization reviews (02/18/10 – 03/08/10)

ODG have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was lifting an oven of unknown weight to place it into the cabinet on xx/xx/xx when she heard a pop in her lower back and felt immediate pain.

Following the injury, the patient was seen at Urgent Care by , M.D., for burning pain in the back. Examination of the back revealed decreased range of motion (ROM) and tenderness. Dr. assessed low back pain and acute sprain and prescribed Lortab.

Magnetic resonance imaging (MRI) of the lumbar spine revealed L4 superior endplate subacute compression fracture with 15-20% loss of vertebral body height and superior endplate posterior segment minimal retrolisthesis producing minimal central spinal stenosis (11-mm AP dimension of the thecal sac in the midline); increased disc space height at L3-L4 due to the L4 vertebral body superior endplate compression deformity/fracture and intervertebral disc minimal posterior broad-based annular bulge producing very mild impingement of the neural exit canals bilaterally; severe narrowing of L5-S1 intervertebral disc space most marked posteriorly due to severe dehydration/degeneration of intervertebral disc with minimal posterior broad-based annular bulge and mild impingement of the left neural exit canal; and midline posterior spinal canal 2 cm long x 1.2 cm wide x 0.8 cm AP simple Tarlov cyst at the level of S2 which appeared to be displacing and compressing several nerve roots anteriorly.

In January 2010, D.O., saw the patient for bilateral low back pain and occasional thigh pain. History was positive for osteoporosis. Examination revealed slightly antalgic gait, tenderness on the left paraspinal area at the L4-L5 level and slightly superior to that level and global weakness due to deconditioning in the thigh muscles. X-rays revealed very minimal apex left scoliosis with the apex at L2, moderate-to-severe disc space narrowing at L5-S1, compression of superior endplate of L4 measuring approximately 15% of the vertebral body height, anterior wedging of the vertebra, mild anterior osteophyte at L3 superiorly and calcification of the anterior vasculature of the lumbar spine. Dr. assessed L4 vertebral body compression fracture and lumbar degenerative disc disease (DDD) at L5-S1 and referred him for further evaluation and management including possible injections and possible vertebroplasty.

M.D., an orthopedic surgeon, saw the patient for low back pain with numbness and anterior thigh pain. Examination revealed increased low back pain with resisted hip flexion, abduction and adduction and seated straight leg raising. On x-rays, Dr. noted calcification within the anterior vessels, multilevel degenerative changes, superior endplate and notable deformity of L4. He obtained a bone density study that revealed osteoporosis based on the lowest T score among the hips and spine. He recommended osteoplasty at L4 for risk of compression at the levels above and below L4 due to osteoporosis.

In the interim, Dr. refilled Lortab.

In a peer review, M.D. rendered the following opinions: (1) Diagnosis related to the xx/xx/xx, event was an acute L4 compression fracture. (2) The pre-existing disease at L5-S1 was not related to the xx/xx/xx, work event. She did have pre-existing osteoarthritis, with the only area of aggravation of this at the L4 level. (3) An osteoplasty or kyphoplasty would be reasonable according to the ODG.

Per utilization review dated January 27, 2010, request for osteoplasty at L4 including 22521 and 95920 was denied with the following rationale: *"The ODG does address issues such as kyphoplasty and vertebroplasty. The*

vertebroplasty is traditionally not recommended, and kyphoplasty is considered under study. However, kyphoplasty can be recommended if there is delayed healing of vertebral fractures. In this case, only two months have passed since the injury, and one could certainly not diagnose delayed healing. It can also be used in patients with osteoporotic compression fractures in whom medications, bracing and therapy have failed. These notes do outline the provision of medications, but there is no documentation of bracing or consideration of any other forms of treatment.”

Per reconsideration review dated February 4, 2010, an appeal for osteoplasty at L4 including 22521 and 95920 was denied with the following rationale: *“The request for osteoplasty at L4 is not recommended as medically necessary. The patient is a female who sustained a fracture of L4 due to a lifting injury. Patient has a history of osteoporosis and took Fosamax for two years but stopped taking the medication. There is no recent bone density study on the patient to show the latest bone mineral density. The osteoplasty is being considered because there is greater risk of compression at levels above and below L4. However, the MRI did not show significant decrease in the vertebral body height to warrant surgery. The medical notes on January 14, 2010, indicated that patient has not had physical therapy or injections. There was also limited documentation in the medication history to show that the patient has had an adequate course of pharmacotherapy. Thus, medical necessity is not established for the requested surgery. I attempted to obtain additional clinical information from the requesting provider but was unsuccessful in having a peer to peer discussion despite two phone calls on two separate days.”*

Per utilization review dated February 18, 2010, the request for osteoplasty at L4 including 22521 and 95920 was denied with following rationale *“I spoke to Corey who is Dr. assistant and is authorized to speak for him in regard to peer-to-peer conferencing. She acknowledged that the compression fracture is approximately 20% of body height. The potential for this compression fracture to heal and improvement in symptoms still remains a possibility. The applicable passages from the ODG, 2010, Low Back Chapter relative to kyphoplasty and vertebroplasty are cited above. Adverse determination is respectfully recommended.”*

Per reconsideration review dated March 8, 2010, the appeal for osteoplasty at L4 including 22521 and 95920 was denied with following rationale *“This is a woman who appears to have sustained an acute L4 anterior compression fracture on xx/xx/xx. The records provided after that document back and leg complaints with no evidence of true neurologic deficit. There are x-rays documenting structural stability with a 15 percent loss of anterior vertebral body height and no evidence of a disc herniation. There is no documentation in this medical record of conservative care with home exercises, anti-inflammatory medication, injections, therapy or bracing. ODG discuss use of kyphoplasty and vertebroplasty as procedures under study, and most likely used in patients with osteolytic fractures secondary to tumor. It is not quite clear what procedure osteoplasty is. However, this reviewer will assume this is some type of vertebroplasty/kyphoplasty. Therefore, in light of the fact that this claimant does not have evidence of a tumor and ODG guidelines indicate that vertebroplasty/kyphoplasty is not specifically medically necessary and the fact*

that there is no appearance of any failure of conservative care, then this osteoplasty is not medically necessary.”

On March 30, 2010, Dr. noted the patient had not started physical therapy (PT). Examination findings were unchanged. Dr. refilled Lortab and recommended to start PT. Fosamax and Osclad D were also continued.

Per utilization review dated April 9, 2010 eight sessions of PT are authorized.

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

Osteoplasty is a term that is not recognized by ODG. It is unclear whether the clinician is requesting recognized terms such as kyphoplasty or vertebroplasty, or some other procedure. It is inappropriate to assume which procedure is being requested. ODG provides differing opinions regarding the recognized kyphoplasty and vertebroplasty procedures. It appears that the request for “osteoplasty” has been appropriately denied.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**