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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: T7 vertebral augmentation via kyphoplasty 22523

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Clinical Neurological 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 medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for a T7 vertebral augmentation via kyphoplasty 22523 is not recommended as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 10/04/12-01/09/13
Therapy notes 10/26/11 -01/18/13
Previous utilization reviews 01/25/13 and 03/01/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her mid back. Clinical note dated xxxxx detailed the patient stating that the initial injury occurred when she was moving a popcorn machine and felt a sharp pain on the right side with gradual spreading of pain to the upper back. Pain radiated to the left side of the mid back. Past medical history was significant for previous vertebral fracture with a resulting vertebroplasty procedure in the lumbar spine. Upon exam, the patient had decreased range of motion throughout the trunk specifically with flexion and extension. X-rays revealed a compression fracture at T7. Clinical note dated 10/22/12 detailed the patient continuing with mid back pain without significant radiation of pain. The patient previously underwent no chiropractic, physical therapy, or injection therapy. Activity exacerbated the pain level. The patient utilized hydrocodone and tramadol for pain relief. Clinical note dated 01/09/13 detailed the patient complaining of 9/10 pain in the thoracic spine. No significant symptomology was noted in the extremities. The patient was noted to have no significant neurologic findings in the extremities. The patient demonstrated 5/5 strength with 2+ reflexes throughout. The note details the patient undergoing a MRI of the thoracic spine on 11/09/12 which revealed an acute T7 compression fracture with a 50% height loss. No significant neural compromise was noted.

The previous utilization review dated 01/25/13 resulted in a denial as the requested treatment

was outside of the recommended window of treatment.

The utilization review dated 03/01/13 also resulted in a denial as the request treatment was outside the recommended treatment window of three months.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of mid-back pain with no significant neurologic deficits in the extremities. The Official Disability Guidelines recommend a kyphoplasty provided the patient meets specific criteria to include a fracture less than 3 months old. The date of injury is noted to be xx/xx/xx. Given the time frame involved, this request falls outside the recommended treatment window for kyphoplasty. As such, it is the opinion of this reviewer that the request for a T7 vertebral augmentation via kyphoplasty 22523 is not recommended as medically necessary and the prior denials are upheld.

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

ACOEM-AMERICA 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)