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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/08/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient kyphoplasty at T12-L1 for the lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Neurosurgery

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 the reviewer that the clinical documentation provided for review does not support this request for outpatient kyphoplasty at T12-L1 for the lumbar spine at this time.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
CT thoracic spine and lumbar spine 09/21/09
MRI lumbar spine 09/17/12
Clinical notes 07/18/12-11/01/12
Procedure note 10/23/12
Previous utilization reviews 10/23/12 and 11/06/12 and 11/12/12 and 12/17/12

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back. CT scan of the thoracic spine and lumbar spine dated 09/21/09 revealed multilevel degenerative disc disease throughout the lumbar spine. Mild degenerative changes were also noted in the thoracic spine. Minimal loss of disc height was noted at L1-2 and L2-3. MRI of the lumbar spine dated 09/17/12 detailed a previous posterior unroofing from L2 to L5. Mild degenerative disc disease was noted at L3 through S1 and no canal stenosis was noted. Subacute compression fracture was noted of the superior endplate of T12. Clinical note dated 07/18/12 detailed the patient complaining of low back pain with lower extremity radiculopathy. The patient had undergone physical therapy. Upon exam, tenderness to palpation was noted in the lumbar spine at the spinous and paraspinous regions with pain elicited with flexion and extension as well as lateral motion. Clinical note dated 07/24/12 detailed the patient complaining of worsening low back pain. Clinical note dated 09/27/12 detailed the patient appearing to have a compression fracture on MRI that had been completed on 09/17/12 and the patient was continuing with a home exercise program. Clinical note dated 11/01/12 detailed the patient undergoing an epidural injection which provided very minimal relief. Upon exam, no neurological deficits were noted. Pain was

noted to be isolated at the T12 level. Procedure note dated 10/23/12 detailed the patient undergoing a transforaminal epidurogram at T12-L1 as well as an epidural steroid injection.

Previous utilization review dated 10/23/12 resulted in a denial for a kyphoplasty secondary to a lack of significant clinical findings that would indicate a kyphoplasty. Additionally, no clinical documentation was noted regarding completion of conservative care.

Peer review dated 11/01/12 resulted in a denial secondary to a lack of significant clinical findings indicating a compression fracture.

Previous utilization review dated 12/17/12 resulted in a denial for kyphoplasty secondary to a lack of significant clinical findings indicating the need for a kyphoplasty.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation provided for review notes the patient complaining of ongoing low back pain. A kyphoplasty would be indicated provided that the patient meets specific criteria, including unremitting pain and functional deficits secondary to a compression fracture, lack of satisfactory improvement with medical treatment, absence of alternative causes for pain, affected vertebrae being at least one third its original height, and fracture age not exceeding three months. There is a lack of clinical information regarding the level and degree of the height of the affected vertebrae. A lack of recent imaging studies was submitted for review to confirm vertebral height. Additionally, there is notice in the clinical notes regarding previous conservative treatment; however, no documentation was submitted regarding the dates and number of sessions the patient had completed. Given the lack of clinical information regarding the imaging studies confirming the disc height loss and the completion of all conservative measures, this request does not meet guideline recommendations. As such, it is the opinion of the reviewer that the clinical documentation provided for review does not support this request for outpatient kyphoplasty at T12-L1 for the lumbar spine at this time.

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)