

Notice of Independent Review Decision

DATE OF REVIEW: 06/07/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Kyphoplasty Levels T6-7

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

The TMF physician reviewer is a board certified interventional radiologist with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the kyphoplasty Levels T6-7 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 02/20/13
- Decision letter with review summary and ODG indications for surgery kyphoplasty – 03/06/13, 04/04/13
- Office visit notes – 11/21/12 to 01/03/13
- Report of CT scan of the chest – 01/07/13
- Report of x-ray of the sternum – 12/04/12

- Report of CT scan of the spine – 02/06/13
- Predetermination/Pre- certification Request – 03/01/13, 04/02/13
- Letter of appeal – 04/02/13
- Office Visit Notes – 02/19/13 to 02/27/13
- Procedure Order Form for kyphoplasty – no date
- Office Visit Notes – 01/02/13 to 01/23/13
- Report of MRI of the thoracic spine – 02/27/13
- Request for CT of chest, abdomen and L-S spine – 01/28/13

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he fell from a ladder approximately 12 feet high resulting in injury to his scalp and chest. The patient continues to complain of chest and mid back pain that is described as sharp, shooting and achy at times. A CT scan in February 2013 revealed a T6-T7 compression fracture. He has been treated with pain medication and physical therapy. The physical therapy note of 12/17/12 indicates that his pain is 0/10 and he is working in modified activity. There is a request for the patient to undergo a kyphoplasty at levels T6 – T7.

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

According to the multi-specialty American College of Radiology White paper: “The major indication for vertebral augmentation is the treatment of symptomatic osteoporotic vertebral body fracture refractory to medical therapy.” “Failure at medical therapy is defined as: 1. For a patient rendered non-ambulatory due to pain or pain persisting at a level that prevents ambulation despite 24 hours of analgesic therapy. 2. For a patient with sufficient pain from weakened or fractured vertebral body physical therapy is intolerable, pain persisting at that level despite 24 hours of analgesic therapy. 3. For any patient with weakened or fractured vertebral body, unacceptable side effects such as excessive sedation, confusion or constipation due to the analgesic therapy necessary to reduce pain to a tolerable level.”

In this case, the patient was able to ambulate and tolerate physical therapy. The note from Advance Imaging of 02/19/13 indicates that pain had decreased to 5/10, was improved with Ibuprofen and that the patient was able to work light duty. Physical therapy notes in December 2012 indicate that the patient’s thoracic pain is 0/10.

In summary, this patient was able to ambulate, tolerate physical therapy and work light duty as soon as one month after his injury. He cannot be considered as a failure of medical therapy. He does not meet the indications for vertebral augmentation or kyphoplasty at this time.

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)**

ACR – ASNR – ASSR – SIR – SNIS Practice Guideline For The Performance of Vertebral Augmentation (sponsored by the American College of Radiology (ACR), American Society of neuroradiology (ASNR), The American Society of Spine Radiology (ASSR), Society of Interventional Radiology (SIR) and the Society of Neurointerventional Surgery (SNIS), last revised 2011 available at ACR.org