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**Notice of Independent Review Decision**

**DATE OF REVIEW:** SEPTEMBER 16, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Kyphoplasty, with biopsy 22524-72291, 62269-77002.

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

M.D., 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)

I have determined that the requested kyphoplasty, with biopsy 22524-72291, 62269-77002 is not medically necessary for the treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Requests for a Review by an Independent Review Organization dated 8/16/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) 8/27/13.
3. Notice of Case Assignment dated 8/27/13.
4. Back Institute and Orthopedics request dated 7/1/13.
5. Back Institute and Orthopedics Progress Notes dated 7/15/13 and 6/26/13.
6. Doctors Hospital: MRI L-Spine without Contrast dated 5/3/13.
7. Denial documentation dated 8/5/13 and 7/10/13.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reportedly sustained an injury on xx/xx/xx. A progress note dated 7/15/13 documents x-ray findings showing compression fracture of L4 with about 40% of loss of height. On 5/3/13, a magnetic resonance imaging (MRI) of the lumbar spine revealed L4-5 disc desiccation and a posterior disc bulge with a ligamentum flavum hypertrophy, resulting in severe canal stenosis and lateral recess narrowing. Also noted were bilateral facet hypertrophic changes with mild bilateral neural foraminal narrowing. At L5-S1, there was desiccation with disc height loss posteriorly as well as a central disc protrusion, effacing the anterior thecal sac, without central canal stenosis. There were bilateral facet hypertrophic changes with moderate left-sided neural foraminal narrowing. It was noted in the findings that there is an acute compression deformity at the L5 vertebral body with loss of height and central body edema. On 6/26/13, the patient was seen in clinic for complaint of low back pain. She stated she fell and was treated in the hospital. The MRI reviewed demonstrated a fracture at the vertebral body at L4, thought to be related to the injury. Upon exam, she had complaints of low back pain and tenderness to percussion was noted to the lumbar spine consistent with that of a compression fracture. An x-ray report dated 7/15/13 indicated that there was a compression fracture of the 4<sup>th</sup> vertebra with approximately 30% to 40% loss of height.

On 7/10/13, a utilization review determination had revealed that the requested kyphoplasty with biopsy was not considered medically necessary as there is lack of documentation of a compression fracture at L4. The URA states that the Official Disability Guidelines (ODG) state that the requested kyphoplasty with biopsy 22524, 72291, 62269, 77002, from 7/15/13 to 9/5/13 is not medically necessary. The URA indicates that records have not been provided x-ray documenting findings of a compression fracture at L4.

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

Guidelines support a kyphoplasty for an acute to subacute fracture failing conservative measures with the diagnosis of osteoporosis. However, based on the ODG, this patient's records do not demonstrate an indication for the requested procedure. Specifically, the records are unclear whether there is a compression fracture at L4 or L5. Further, there is a lack of documentation of significant current conservative care including physical therapy has been exhausted. Moreover, the patient's records do not provide evidence that the patient is osteoporotic. All told, the kyphoplasty, with biopsy 22524-72291, 62269-77002 is not medically necessary due to inconsistencies on imaging studies, lack of documentation of significant conservative care, and inadequate documentation of osteoporosis as the patient's diagnosis.

Therefore, I have determined the requested kyphoplasty, with biopsy 22524-72291, 62269-77002 is not medically necessary for treatment of the patient's medical condition.

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**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 JUDGMENT, 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)