

MEDR X

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DATE OF REVIEW: February 15, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Perq lumbosacral (Kyphoplasty L1) under fluoroscopy injection, inpatient for 1 day- lumbar spine

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

The reviewer is a Medical Doctor who is 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)

The reviewer disagrees with the previous adverse determination regarding the medical necessity of: Perq lumbosacral (Kyphoplasty L1) under fluoroscopy injection, inpatient for 1 day- lumbar spine

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a XXXX who sustained an XX on XXXX. Injury occurred when XXXX. XXXX was diagnosed with an L1 compression fracture. The XXXX procedure report documented a lumbar epidural steroid injection was performed at L4/5. The XXXX lumbar spine MRI impression documented anterior and central compression deformity of L1 up to 60% anterior height loss and superior endplate edema. There was a 2.5-3.0 mm protrusion of the posterosuperior endplates of L1, resulting in T12/L1 central canal narrowing. There was multilevel spondylosis with disc space narrowing, disc dehydration, endplate irregularity, endplate spurring, annular disc bulges, and annular tear, in association with ligamentum flavum hypertrophy, resulting in multilevel central canal stenosis and impingement of the traversing nerve roots. There was multilevel neuroforaminal narrowing. Lumbar spine exam documented pain with motion, decreased flexion, upper lumbar tenderness, and normal gait. Lower extremity neurologic exam documented normal strength, sensation, and deep tendon reflexes. The XXXX orthopedic report cited a chief complaint of low back pain, present for XXXX. XXXX had tried positional changing to relieve XXXX pain/symptoms. Initial treatment had included physical therapy and steroid injection. The history of injury was reviewed. XXXX sustained an L1 compression fracture and had an apparent re-injury along the way likely during XXXX therapy. There was a further collapse of the bone which was documented by the x-ray done in XXXX and the most recent MRI confirmed further collapse of the bone and continued edema along the superior endplate. It was recommended that XXXX use a TLSO brace. The treatment plan recommended a discussion of kyphoplasty which XXXX wanted to delay until XXXX. The XXXX orthopedic report cited a chief complaint of low back pain. Pain was rated as grade 8/10. Symptoms included pain with motion, limited range of motion, weakness,

and numbness and tingling. Pain was constant and worse with certain movements. Pain was increased with prolonged sitting, standing, and walking, and with transitions, physical activity, and bending over. MRI was reviewed and showed edema within the vertebral body under the superior endplate at L1 due to a compression fracture with loss of approximately 30 to 40% of the vertebral body height at that level. There was slight retropulsion of the posterior superior corner of the endplate which pushed into the epidural space but did not cause any nerve compression. There were disc bulges and annular tearing from L2 down to S1 which caused significant bilateral neuroforaminal stenosis as well. There was prominent loss of disc space height at L5/S1. The diagnosis was L1 compression fracture. XXXX continued to have pain associated with the L1 compression fracture which had not healed. XXXX was ready to move forward with a kyphoplasty. The undated addendum to the XXXX orthopedic report indicated that the XXXX MRI of the lumbar spine confirmed an L1 compression deformity of up to 60% anterior height loss compared to the XXXX L1 compression fracture of 20 to 30%. These findings were significant and proved they were progressive. This situation is an exception to the Official Disability Guidelines (ODG) criteria of 3 months. It was noted that patients with compression fractures and progressive loss of vertebral body height may develop excessive thoracic kyphosis and lumbar lordosis. Compressive fractures may lead to progressive loss of stature and continuous contraction of the paraspinal musculature to maintain posture, and additional outlined complications. This claimant was an exception to the ODG due to the obvious progressive nature of XXXX compensable condition. XXXX required kyphoplasty to alleviate pain and correct the sagittal imbalance of the spine. The XXXX appeal letter submitted by the claimant documented the history of injury and treatment. XXXX reported initial care was provided under XXXX private health insurance with recommendation for kyphoplasty. When it became a workers compensation case in XXXX, XXXX current physicians were not able to continue XXXX care. XXXX transferred care to another physician who ordered 6 sessions of therapy. XXXX was then referred to another physician who indicated that XXXX was not a candidate for kyphoplasty and recommended pain management injections. XXXX underwent an injection with increased pain, and completed 8 additional sessions of physical therapy with pain after therapy. XXXX underwent additional consultations with recommendations for kyphoplasty. XXXX was provided a back brace to wear before and after surgery. XXXX reported that the fracture had gone from 15% loss to a 50% loss. XXXX was not able to walk and stand for long periods of time and XXXX was not able to do a lot of things without pain. XXXX reported difficulty climbing stairs, lying on XXXX back, getting in and out of bed, and bending over with motion. XXXX reported pain with lifting more than 5 pounds, increased pain when XXXX overdid things, and inability to take care of XXXX. The majority of XXXX pain was in the lower back with intermittent pain in other areas, hips, pelvis, calves and upper back. In the last several weeks, XXXX was experiencing neck pain and stiffness, occasional pinching and mild headaches. XXXX stated that XXXX was very active and wanted to continue working and be able to take care of XXXX XX. XXXX stated that if XXXX didn't have surgery, the fracture was going to continue to get worse and then what were XXXX options.

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

The prospective request for Kyphoplasty L1 under fluoroscopy with one day inpatient stay is medically necessary. The denial of this request is overturned. The Official Disability Guidelines state that kyphoplasty is recommended as an option for patients with pathologic fractures due to vertebral body neoplasms, who may benefit from this treatment, but under study for other vertebral compression fractures. Surgical indications include presence of unremitting pain and functional deficits due to compression fractures due to osteolytic metastasis, myeloma, hemangioma (recommended) or osteoporotic compression fractures (under study), lack for satisfactory improvement with medical treatment (e.g. medications, bracing, therapy), absence of alternative causes for pain such as herniated disc, affected vertebra is at least 1/3 of its original height, and fracture age not exceeding 3 months. Guidelines recommend a best practice target inpatient length of stay up to 3 days following kyphoplasty.

This claimant presents with persistent low back pain following a XXXX. XXXX was diagnosed with a compression fracture at L1. Initial treatment included activity modification, physical therapy and epidural steroid injections. It was noted that XXXX had sustained an initial L1 compression fracture in XXXX with 20-30% disc height loss with additional re-injury likely due to physical therapy. The XXXX lumbar spine MRI documented a progression of the vertebral compression fracture to 60% anterior vertebral height loss with superior endplate edema. There is also imaging evidence of multilevel spondylosis from L2 to S1 with disc space narrowing, disc dehydration, endplate irregularity, endplate spurring, annular disc bulges, and annular tear, in association with ligamentum flavum hypertrophy, resulting in multilevel central canal stenosis and impingement of the traversing nerve roots. However, there are no clinical exam findings of neurologic deficits or radicular signs/symptoms to suggest pain generator other than the compression fracture. XXXX has failed long-term reasonable and/or comprehensive conservative treatment, including bracing, activity modification, and physical therapy. The orthopedic surgeon indicates that an exception to the Official Disability Guidelines timelines for kyphoplasty is warranted based on the progressive nature of the compression fracture, acuity of the fracture based on imaging evidence of superior endplate edema, and to avoid further and significant complications. A relative exception to guideline timelines is reasonable based on imaging evidence of superior endplate edema and progressive vertebral height loss suggestive of an acute/subacute process. Therefore, this prospective request for kyphoplasty at L1 with one-day inpatient stay is medically necessary.

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 KNOWLEDGBASE
- 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

ODG Treatment

Integrated Treatment/Disability Duration Guidelines

Low Back - Lumbar & Thoracic (Acute & Chronic)

Updated 12/28/17

Kyphoplasty

Hospital length of stay (LOS)

- 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)