Applied Independent Review

An Independent Review Organization

P. O. Box 121144 ***Fax Number:***

Arlington, TX 76012 **(817) 349-2700**

Email:appliedindependentreview@irosolutions.com

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery
Orthopaedic Sports Medicine
Adult Spine Surgery

Description of the service or services in dispute:

Verebral Augmentation at L3

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)

Patient Clinical History (Summary)

The patient is a XXXX with a history of an occupational claim from XX. The mechanism of injury is detailed as a XX. Prior relevant treatment includes a cervical collar, lumbar brace, medication and physical therapy. The XX lumbar MRI found marrow signal abnormality compatible with edema or hemorrhage within the bodies of L3, L4 and L5 compatible with acute trabecular impaction or compression. The XX electro-diagnostic studies of the bilateral lower extremities show positive electro-diagnostic evidence of bilateral L4 lumbosacral radiculopathy both acute and chronic in nature. The XX lumbar MRI found chronic mild deformity/mild compression deformity of the superior endplates of L2, L3 and L4 vertebral bodies towards the right. The patient reported pain was a 6/10 and unchanged in the low back and neck. The patient reported stiffness that was persistent, radicular bilateral leg pain and numbness in the left lower leg. There was decreased range of motion, hypoesthesia in the left L5, left S1 and S2 distribution. There was pain elicited over the left posterior superior iliac crest at L3-4, L4-5 and L5-S1. The patient had a positive bilateral pelvic rock test. The patient was diagnosed with low back pain, neck pain, cervical radiculopathy and upper back pain. The patient was recommended to proceed with caudal epidural steroid injection and vertebral augmentation "L4 and L5 first and proceed with L3–ESI will be the caudal approach as we do not want to go to the fracture area".

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The Official Disability Guidelines state 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, consistent with recent higher quality discouraging studies of a similar procedure, vertebroplasty. In this case, while the documentation reports the patient had unremitting pain and lack of satisfactory improvement with medical treatment, the medical records do not support that the affected vertebra is at least one third of its original height. Furthermore, the fracture is attributed to the XX accident, which is greater than XX at the time of the recommended augmentation and studies did not

evaluate fractures older than XX. Lastly, there is no documentation of bisphosphonate therapy. As such, the denial of Vertebral Augmentation at L3 is not medically necessary and upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ 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 and Treatment

- ☑ Guidelines Pressley Reed, the Medical Disability
- ☐ Advisor

Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters

- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)