C-IRO,Inc.
An Independent Review Organization
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Notice of Independent Review Decision

IRO REVIEWER REPORT TEMPLATE – WCN

DATE OF REVIEW: **JUNE 27, 2007**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Inpatient Surgery 360 L4-S1

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
MRI lumbar spine without contrast, 07/19/05
EMG, 08/03/05
Peer review, 08/19/05
Behavioral medicine consultation, 10/05/05
Office note, Dr. 10/14/05, 06/16/06, 09/11/06, 10/17/06, 04/02/07

MRI lumbar, 06/08/06
Lumbar discography L3-5, 08/08/06
CT lumbar spine, 08/08/06
Team conference, 12/19/06
Psychiatric evaluation, 01/04/07
Chiropractic visits, 04/12/07 to 05/01/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant reportedly sustained a low back injury with low back and right leg pain. An MRI of the lumbar spine done on 07/19/05 showed straightening of expected lordosis that may reflect muscular pain or spasm. At L4-5, there was a focal right posterior central disc protrusion which indented the thecal sac to a mild to moderate degree. An EMG/NCS followed on 08/03/05 which showed a right L5 radiculopathy.

On a 10/14/05 physician visit, the claimant reported low back and right leg pain associated with intermittent numbness and tingling into the right toe. It was noted that the claimant had undergone an epidural steroid injection in August 2005 with no improvement. An examination revealed no neurological deficits. Flexion extension x-rays showed no significant abnormalities, some mild lumbar scoliosis and thinning of the fact joints at L5- S1. On lateral views there was good maintenance of disc space height at all levels. The claimant was diagnosed with lumbar syndrome and right L5 radiculopathy.

A repeat lumbar MRI done on 06/08/06 showed disc protrusions at L3-4, L4-5 and L5- S1 that minimally indented the thecal sac. A discogram was then recommended and performed on 08/08/06 which showed concordant back pain at L4-5 and L5- S1. The post lumbar CT showed a grade II annular tear at L5-S1 and a bulging annulus contacting the traversing ventral roots at the lateral recess.

On a 09/11/06 physician re-evaluation, it was noted that an intradiscal electrothermal annuloplasty procedure had been recommended and was denied by the insurance carrier. A psychiatric evaluation followed on 01/04/07 which diagnosed a major depressive disorder, alcohol abuse and cannabis abuse. On 04/02/07, progression of the claimant‘s back and leg pain was noted despite a pain management program. The treating physician recommended total discectomies at L4-5 and L5- S1 through an anterior approach with interbody fusion and posteriorly a decompression laminectomy at L5 transverse process fusion at L4-5 and segmental fixation L4, L5 and S1 bilaterally.

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

There is no compelling reason, based on review of records available, as to the indications for the claimant undergoing the 360 fusion at L4-S1 as proposed. It was noted from a careful review of the medical records that although this gentleman reportedly has evidence of radiculopathy on EMGs, the MRI scans do not describe significant neural compression. It appears, in fact, that the preponderance of this gentleman's symptoms is in the low back. Furthermore, in spite of the fact that this gentleman reportedly has positive discograms at two levels, he represents a poor candidate for proposed surgery based on his substance abuse and major depressive disorder. Those alone, in the Reviewer's opinion, would suggest that he is unlikely to see meaningful benefit from the extensive surgery as outlined.

Therefore, in the absence of documented instability or progressive neurological deficit, and that the existence of major psychological overlay would suggest that this gentleman, in the best of circumstances, is a poor candidate for surgery, the Reviewer cannot recommend the proposed surgery as being either reasonable or medically necessary. As such, the Reviewer agrees with the previous determination of the insurance carrier as outlined.

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**

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back: Fusion
Not recommended for patients who have less than six months of failed conservative care unless there is severe structural instability and or acute or progressive neurological dysfunction.
"Patient Selection Criteria for Lumbar Spinal Fusion." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of recommended conservative therapy.

☐ **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)**