

**C-IRO, Inc.**  
**An Independent Review Organization**  
7301 Ranch Rd. 620 N, Suite 155-199  
Austin, TX 78726

Notice of Independent Review Decision

**DATE OF REVIEW:** NOVEMBER 20, 2007

**IRO CASE #:**

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

ALIF L5-S1 with Fusion x 2 Day LOS

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letter, 10/01/07  
Adverse Determination Letter, 10/18/07  
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back-Fusion  
MRI lumbar spine 06/07/07  
Office notes of Dr. 08/20/07, 09/12/07, 10/11/07  
EMG 08/31/07  
CT myelogram 09/04/07  
Note of, MS, LPC 10/22/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a xx year old male injured on xx/xx/xx lifting more than 100 pounds. He has been treated for low back and left leg pain to the calf and foot. He has had therapy, home exercise program, chiropractic care, medications, TENS, heat and ice.

A 06/07/07 MRI of the lumbar spine showed no compression, spondylolisthesis or spondylosis. There was one level of abnormality: L5-S1 revealed moderate loss of disc space height with early endplate changes. There was a broad based protrusion with effacement of the thecal sac but no central or neural foraminal compromise.

On 08/20/07 Dr. saw the claimant for low back pain to left leg to foot since injury. The claimant had numbness and tingling in the calf and Achilles. He had quit smoking two years prior. Strength was 5/5 and reflexes were normal with no Hoffman's or clonus. Sensation was intact and there was a negative straight leg raise. The impression was mechanical low back pain.

The 08/31/07 EMG documented bilateral L5 radiculopathy, worse on the left. The NCS was consistent with bilateral peroneal motor neuropathy and sensory neuropathy of the bilateral sural, saphenous and left lateral cutaneous nerves. A 09/04/07 CT myelogram showed L4-5 marginal bony osteophytes and an annular bulge. There was L5-S1 anterior interspace marginal bony osteophytes noted. The surgery was denied on 01/01/07 and 10/18/07. Following that he had a psychological evaluation completed on 10/22/07 and was cleared for surgery.

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

This xx-year-old gentleman has been referred for anterior lumbar interbody fusion L5-S1. Based on records available, he has been through an extended course of conservative treatment including physical therapy, exercises, chiropractic, medical management and a transcutaneous electrical nerve stimulation unit. Reportedly, he has also been through a psychological evaluation and was deemed a reasonable candidate for the proposed surgery.

That said, the records, although documenting degenerative change at the lumbar spine, do not, in my opinion, identify compelling indications for the proposed surgery. In particular, this gentleman has degenerative change at both L4-5 and L5-S1 based on CT myelogram. There is no indication that discography or other efforts have been undertaken to determine the pain generator in this gentleman's case. In particular, based on degenerative change at the level above the proposed fusion level, it would appear at the very least to address this in discussions regarding the indications for surgery. As such, I cannot in this setting, submit that this gentleman's clinical information supports the medical necessity for the proposed surgery, and in particular, it does not meet with ODG criteria regarding that proposed surgery.

Official disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back-Fusion

**Pre-Operative Surgical Indications Recommended:** Pre-operative clinical surgical indications for spinal fusion should include all of the following:

- (1) All pain generators are identified and treated; &
- (2) All physical medicine and manual therapy interventions are completed; &
- (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see [discography criteria](#)) & MRI demonstrating disc pathology; &
- (4) Spine pathology limited to two levels; &
- (5) [Psychosocial screen](#) with confounding issues addressed.
- (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing

**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)**